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ABSTRACT

The purpose of this manual is to guide and assist alcohol and other drug abuse treatment programs to maximize cost recovery from third party reimbursements. It is intended to be a guide for planning and decision making rather than a resource manual. The text is based on the experiences of agencies in six states participating in a demonstration project designed to identify problems in developing and implementing third party payment systems. Key issues such as client and provider eligibility and services are covered. Third party payment mechanisms are described, including medicaid, supplementary security income, and health insurance. Other topics include confidentiality, administrative and financial management of treatment and rehabilitation programs, record keeping, collection procedures, and cost-finding procedures. Sample billing forms are also included. (JAC)

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ALTERNATIVE FUNDING RESOURCES MANUAL FOR DRUG ABUSE AND ALCOHOL TREATMENT AND REHABILITATION PROGRAMS

by Cliff Bertagnoli

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FOREWORD

The world of third party reimbursement is broad. Those who enter this world do so at peril of becoming overwhelmed by a mass of details, some relevant, some irrelevant but all confusing to a novice. This manual has been prepared in the belief that a guide is necessary to help programs chart their courses through the heretofore largely unexplored territory of third party reimbursement (TPR).

The purpose of this manual is to guide and assist alcohol and other drug abuse treatment programs to maximize their recovery from third parties. It is the goal of this manual to provide a process by which each treatment program may determine rationally and without undue effort the directions it should take.

The emphasis is upon only that part of the world of TPR which is relevant to the circumstances in which alcohol and other drug abuse treatment programs most frequently find themselves. It is intended to be a guide to planning and decision making rather than a resource manual or encyclopedia of third party reimbursement.

The major stress is upon the practical problem of how the treatment programs in the state can attempt to maximize recoveries from third parties. This text has grown from the experiences gained in agencies of six states participating in a demonstration designed to identify the problems which they experienced as they attempted to develop and implement third party payment systems.

Because of the dynamic nature of the issues related to the financing of health care services, some of the information presented may be subject to change. If changes occur, replacement pages will be sent to the holders.

The Bureau of Alcohol and Other Drug Abuse welcomes feedback from those who have used this manual. Comments on the usefulness of the material are especially welcome. We are also interested to know whether any topics may have been treated too briefly or omitted altogether. Reactions to the clarity and organization of the manual will be helpful in making revisions. Communications should be addressed to Clifford Bertagnoli, Bureau of Alcohol and Other Drug Abuse, 1 West Wilson Street, Madison, Wisconsin 53702.

CHAPTER 1

INTRODUCTION TO HEALTH SERVICES FUNDING

THE SOURCES

The sources of TPR may be classified broadly into two general categories: those with a medical orientation, and those with a social service orientation. Sources with a medical orientation usually require a provider to follow a medical staffing model. Typically, these sources require that services be delivered by, under the supervision of, or at the direction of, a physician. Sources with a social service orientation tend to reimburse for services that focus on helping individuals function more effectively in society.

The distinction between sources with a medical as opposed to a social service orientation is not clear-cut. Some sources with a social service orientation will cover medical services. The important point is that the services covered by a source may not entirely correspond to the package of services offered by a treatment program. Indeed, the services covered by any of the sources available to a treatment program may not correspond to the package of services offered by the program.

Major sources of TPR that may be available to programs include:

Medically Oriented Sources	Social Service Oriented Sources
Medicaid	Title XX
Private Health Insurance	Food Stamps
HMO's	Bureau of Prisons
CHAMPUS	Welfare, including SSI
Medicare	Vocational Rehabilitation
	Special State Programs

WHAT IS THE THIRD PARTY PAYMENTS SYSTEM?

The three parties in a third party payments system are clients (or service recipients), service providers, and payors. Third party payment is reimbursement to the service provider by a source other than the recipient of service.

Third Party Reimbursement in Perspective - The Program must have a clear notion of where it fits in the scheme of things before launching a program to maximize third party reimbursement. Consider therefore the federal policies, the premises on which third party efforts should be based, the significance of TPR and TPR limitations.

FEDERAL POLICIES

The Health Services Funding Regulations, effective January 1, 1974, require that federally assisted health care delivery programs, including drug abuse treatment programs, make every effort to obtain maximum funding from third party payors and other sources. In March, 1975, the official guidelines for these regulations were promulgated and provided that the goals of the regulations were to:

1. permit grant dollars to be used most productively;

2. to assist projects, to the greatest extent possible, to develop alternate of supplementary sources of support; and

3. to prepare projects for the possible changes which adoption of a national health insurance plan may bring about.

The regulations require that federally assisted projects submit a general plan and a financial plan reflecting the use of third party resources and other sources of funding.

The general plan, submitted as part of a grant application, must contain short and long term plans describing goals and objectives, the approaches used in meeting them, and the method of monitoring and evaluating effectiveness of the reimbursement effort.

The financial plan should include planning assumptions, descriptions of financial arrangements used to supplement or supplant ADAMHA funds, projections of total income by source, number of persons covered, billings and payments by source.

Premises: To maximize TPR, a program must start from certain premises regarding the funding of alcohol and other drug abuse treatment programs. If the Program is to mount an effective plan to maximize reimbursements, these premises must be understood.

Principal among the premises are:

. Existing sources of TPR are not adequate to permit treatment programs to rely on them as a sole or even a principal source of funds.

. Funds available for Federal grants will not increase and may decrease from current levels.

. Federal "match" under Federal grants will decline.

. At some future date there will be a program of national health insurance which will broaden existing patterns of coverage to encompass some alcohol and other drug abuse treatment services but will leave sufficient "gaps" so that third party reimbursement will not be adequate itself to provide a sole source of support for programs.

. Alcoholics and other drug abusers will not be denied admission to treatment or discriminated against in the delivery of service solely by virtue of their lack of third party coverage.

. Treatment programs will not be expected to change existing staffing patterns to conform to a medical model solely for purposes of maximizing third party reimbursements.

. Programs will be expected to conform to a medical model if it is economically viable and can be done without making major changes in existing staffing patterns.

. The effort to maximize TPR should be viewed as an integral part of a broader effort to improve the efficiency, quality of treatment

and management of treatment programs. Adapting to TPR may be regarded as a test of the vitality of a treatment program.

. Responsibility to maximize the TPR rests with treatment programs, but the BAODA must support and facilitate their efforts.

. A system of accreditation by the Joint Commission on the Accreditation of Hospitals may be implemented and will be accepted by private carriers as a necessary condition for provider eligibility.

. The client with third party coverage will not be deprived of his right to confidentiality in the treatment process. If a client asserts this right, and it would be compromised through the claim filing or billing process, reimbursement should not be sought on his behalf.

. The potential for reimbursement will vary widely among modalities within a program and among programs within the state. Hence, the degree to which programs commit themselves to maximizing TPR should be related to the potential for recovery.

SIGNIFICANCE OF TPR

One who would be committed to a policy of maximizing TPR, should understand the rationale for policy. In brief, one must be able to answer the question, "Why bother with TPR?" with something other than "HEW has mandated that it be done." Consider now five basic reasons to maximize TPR.

1. TPR is a Way of Maintaining Current Treatment Capacity.

As the federal matching share declines some source of funding must be substituted or the program will necessarily contract to a level of funding at which match requirements can be met. Programs which are constrained currently by their ability to command matching funds, and it would appear that most are, must either reduce current operating budgets, principally by cutting back staff, or attempt to increase third party recoveries or some combination of the foregoing. Programs which are not constrained by the ability to command matching funds may be able to substitute matching funds so as to reach the desired level of funding without recourse to third party funds. A more likely case is one where the program will obtain a modest increase in matching funds, increase recovery from third parties slightly, and suffer a small reduction in funding level.

2. TPR Can Help Offset the Effect of Inflation.

If a program is constrained by the ability to command matching funds, inflation will begin to squeeze the program as higher funding levels become necessary to maintain the same treatment capacity, but the program is unable to reach the higher funding level for want of an adequate match. Given the pace of inflation, it would seem inevitable that unless matching funds increase at a

similar rate treatment programs will be "squeezed." TPR provides an avenue to offset some of this squeeze.

3. TPR Can Offset the Vagaries of Grant Funding.

   The process of grant funding is fraught with many uncertainties. Since ultimately the availability of funds is determined by a congressional appropriation process in which NIDA and NIAAA compete against many other agencies for a limited supply of funds, there is no guarantee that Congress will smile consistently upon the institutes as they set priorities for the allocation of federal dollars. Furthermore, each treatment program (grantee) is competing with other treatment programs (grantees) for a limited supply of federal dollars. There is no guarantee that a given grantee will consistently compete on favorable terms with other grantees. TPR offers a way of obtaining some protection from the uncertainties of the grant process.

4. TPR Offers Greater Flexibility in the Allocation of Funds.

   Grant funds are usually earmarked for a specific purpose such as staff salaries. There are clear limitations on how these funds may be spent. Thus it is possible for anomalies to arise in a program such as having adequate staff but inadequate office supplies. Because TPR funds are not earmarked, they can be used as necessary to complement the earmarked grant funds.

5. TPR is a Way of Upgrading the Quality and Management of Treatment Programs.

   Elements of an administrative system needed to support the third party payment process are also elements of an effective quality and management control system. Knowledge of unit costs, a fee schedule that reflects unit costs scaled by ability to pay, client-specific records of services, treatment plans, and clinical progress notes are useful tools for administering a program, for improving the efficiency of the program and for controlling the quality of services rendered. Efforts to adapt to systems of TPR should not be regarded as merely a mad scurrying about for additional funds. Rather, such efforts should be viewed as an opportunity to improve the operation of treatment programs.

THE LIMITATIONS OF TPR

We shall dispense with obvious limitations such as reimbursement rates which don't cover the unit cost of services, and service coverages which don't encompass all of the services delivered by treatment programs. Consider the less obvious but no less important limitations.

1. Recouping Third Party Funds Imposes an Additional Administrative Burden on Treatment Programs.

   Treatment programs must develop the elements of a system to support the billing process. The elements of the system are not complicated,

and any program can develop a support system with a minimum of technical assistance. Indeed a well-managed program should have these elements in place regardless of whether or not third parties are billed. Thus the burden of implementing the system should be viewed as part of a general effort to improve the management of the programs not just an effort to obtain additional third party funds. If medical clinics, private physician's offices and indeed nearly every service enterprise, however small, in our economy has acquired the ability to bill for services rendered, what reason is there to suppose that treatment programs cannot?

2. TPR May Create Cash Flow Difficulties.

The utilization of alcohol and other drug abuse programs tends to be subject to seasonal fluctuations. During the fall and winter months utilization peaks and gradually subsides during the spring and summer. Fluctuations in program use will produce corresponding fluctuations in reimbursements, hence a varying flow of funds to a program. Under a grant system, cash flow is unrelated to program utilization in the short run and is of little concern to program managers. Where TPR is a major source of funding, cash flow must become a concern of program managers who cannot adjust their cash outlays to conform to the seasonal fluctuation. Conceivably, programs could need some working capital to finance their current expenses during the seasonal "valleys" of utilization.

3. TPR Will Compromise the Right of Clients to Confidentiality in the Treatment Process.

This argument is often used as an excuse for not attempting to exploit sources of third party payments. There is, of course, a risk of exposing a client's identity in the course of filing a claim. Claim forms sometimes flow through an employer's administrative office before being forwarded to a third party payor and may be subjected to the scrutiny of persons from whom a client wishes to conceal the fact of his addiction or treatment.

Clearly the client's right to confidentiality must be respected. However, it remains for the client, not the treatment program, to decide whether this right will be exercised or not. After having been informed of the risk, a client must be given the opportunity to exercise this right or not, as he so chooses. If a client chooses not to exercise this right relative to claim filing, and many will not, a claim should be filed. If a client chooses to exercise this right, a claim should not be filed and admission or treatment of the client should not be prejudiced as a result. Claim filing is thus contingent upon the informed consent of the client.

THE CHALLENGE OF TPR TO TREATMENT PROGRAMS

Treatment programs must exploit the sources of TPR without compromising their mission or effectiveness. Sources of TPR were never intended to apply to alcohol and other drug abuse treatment programs and most

of them apply in somewhat awkward ways. Until the day when alcohol and other drug abuse treatment programs are explicitly recognized as a unique category of provider and thereby accorded provider status, systems of reimbursement must bend to treatment programs, and treatment programs must bend to accommodate systems of reimbursement. In the process of accommodation, treatment programs must not compromise their mission; the trick is to exploit TPR without being distorted in the process.

DEFINITION OF KEY TERMS

The meanings of certain terms should be mastered if the reader is fully to understand the discussions which follow. These terms are:

Accreditation: formal recognition by a non-governmental standard setting body that an organization or program has met certain standards.

Assignment of benefits: the procedure by which a client assigns his right to reimbursement to the provider. The provider is then authorized to collect directly from the third party payor.

Certification:

1. formal recognition by a non-governmental standard setting body that an individual has met certain requirements of that accredited program, acceptable performance on qualifying examinations or completion of a certain work experience.
2. formal recognition by a governmental body that an individual or organization has met certain standards. Usually issued in conjunction with a determination of eligibility or compliance with a statute or regulation.

Client eligibility: the status upon which payment by a third party for services rendered to a client of a treatment program is contingent.

Determinants of reimbursement potential: the six factors which interact to determine the reimbursement potential of a treatment program; number of third party sources available, provider eligibility requirements of the sources, client eligibility requirements of the sources, scope of covered services, reimbursement rate and capabilities of the program to bill for services.

Fee schedule: a listing of the prices charged for the units of service delivered by a treatment program. Usually prices are adjusted according to the client's ability to pay.

Licensure: the process by which a government agency grants permission to an organization or individual to engage in an occupation or profession. It is an exercise of the police power of the state intended to protect the public safety and welfare by ensuring that a certain level of competency has been obtained. Other names are sometimes applied to this process. The principal test of whether such a process qualifies as licensure is whether the power has been granted to punish those who engage in the occupation or

profession without having obtained the grant of state permission or licensure.

Medical model: a staffing pattern in which a physician or psychiatrist adequately supervises the delivery of services to a client. Evidence of adequate medical supervision consists of treatment plans and clinical progress notes signed by the supervising physician or psychiatrist.

Provider: an institution or individual which delivers a service to clients.

Provider number: a control or identification number issued by a third party payor as certification of provider status.

Provider status: recognition by a third party that an institution or individual providing services is eligible to be reimbursed.

Reimbursement potential: the upper limit on the total amount of money that could be recovered from third party sources for services rendered to clients. For a treatment program the reimbursement potential is determined by a set of factors most of which are beyond the control of the program. (See definition of Determinants of Reimbursement Potential.)

Reimbursement rate: the amount a third party payor will pay for a unit of covered service delivered to an eligible client.

Scope of coverage: the extent of the services for which a third party payor will reimburse.

SSI: Supplemental Security Income.

Third party payment: any payment for services rendered to a client made on his behalf by a source other than State and Federal funds as a result of some special status the client possesses. Thus a third party payment is contingent upon: a) the status of the client; b) the delivery of a specific service to the client and; c) the identity of the client. In general either a specific entitlement has vested in the client (Medicaid, private health insurance, food stamps), or the client has established a status as a program beneficiary (Title XX).

Treatment program: any program of therapy, drug free or methadone maintenance, in a residential or outpatient setting, which includes a counseling of clients to ameliorate their dependence on drugs.

Units of service: a distinct category by which to measure the amount of service delivered; for example, an "intake," "counseling visit," "methadone dispensing visit," or "physical examination."

CHAPTER 2

KEY ISSUES

Relationship of State Grant-In-Aid to Collections From Client and Third Parties

Some 51.42/.437 Boards have expressed concern that collections made by them from clients or third parties, such as health insurance, will only serve to reduce their Grant-In-Aid from the State. The concern is that there might be no real benefit to a program through collection from these other sources.

While it is true that collections from clients and third parties are reported as deductions from the quarterly expenditure reports, these revenues are not thereby necessarily lost to the programs as additional sources of funds. Every Board is very conscious of the fact that there is a limited amount of Grant-In-Aid available to them for funding their programs. Section 51.42 (10) (b) states that "...the Department shall review and approve required annual program plans and budgets but shall not approve budgets for amounts in excess of available revenues. It may certify the desirability of programs or services above the approved level of services which are not included in the approved budget."

If a program has expenditures in excess of its Grant-In-Aid allocation, the additional funding must come either from collections or from a county appropriation. It is unlikely that a program would be satisfied in providing services only to the extent of the allocation limit established for the Grant-In-Aid, but if that is the situation, then any fee collections would reduce the amount of the allocation to the program. The usual situation is that the allocation from the Grant-In-Aid to each Board does not meet the expenses to provide needed services, and that other funding is necessary to carry out the total program.

The mechanical procedure to report fee collections as an offset to the Grant-In-Aid does not interfere in meeting these additional expenses. This mechanical procedure is necessary so that actual expenses of a program are not double-funded, once by fee revenues and then by Grant-In-Aid. Section 51.42(8)(g) requires that each Board retain 100% of all collections it and its providers make for care other than that provided or purchased by the State. There is clear authority in Section 51.42(8)(h) that indicates fee collections may be applied to expand the programs at the discretion of the Board, as well as cover costs of primary services, exceptional and specialized services, or to reimburse supplemental appropriations funded by counties.

The Department does require that if a program is expanded or upgraded subsequent to the approval of the original budget for the fiscal year, that a revised budget be submitted indicating the fiscal impact resulting from the change. Administrative Order 1.42, C, 2 provides that"...a clear cut audit trail shall exist to insure that monies applied to client accounts are applied to the appropriate source of funding when required."

Clearly then, fee collections do result in a direct benefit to programs when the Grant-In-Aid appropriation falls short of funding the service delivery system. The major criticism of the Grant-In-Aid minimum allocation voiced by the communities has been that the Grant-In-Aid has been inadequate to provide quality services accessible to persons within the jurisdiction of each Board. If this is true, the 51.42/.437 Boards have a great incentive

to capture otherwise untapped third party monies. It should be noted that funds cannot be encumbered or used to establish a contingency fund for future program changes. It is equally important to note that State Grant-In-Aid would not be available to compensate for deficits created by program changes when anticipated revenues fall short of budget estimates.

51.42 MENTAL HEALTH ACT
(8) Grants-In-Aid

(h) Each board established under either s.51.42 or 51.437, or both shall apply all funds it receives under pars. (a) to (d) to provide the services enumerated in ss.51.42(5), 51.437(5) and 51.45(2)(g) to meet the needs for service quality and accessibility of the persons in its jurisdiction, except that the board may pay for inpatient treatment only with funds designated by the department for this purpose. The board may expand programs and services with county and other local or private funds at the discretion of the board. Moneys collected under s.46.10 shall be applied to cover the costs of primary services, exceptional and specialized services or to reimburse supplemental appropriations funded by counties. Boards shall include 100% of collections made by the department under s.46.10 on or after January 1, 1975, for care in county hospitals, as revenues on their grant-in-aid expenditure reports to the department.

CLIENT ELIGIBILITY

Client Eligibility is entitlement of a client to have all or part of the costs of the services he receives from a program reimbursed by a third party. To be eligible for such reimbursement, the individual must either have some form of private medical insurance or meet the criteria established by federal and state agencies for publicly financed medical or social services. Client eligibility criteria for publicly financed programs generally relate to age, physical condition, or economic status.

Determining Client Eligibility

Determining whether a client has, or is eligible for, third party payments is basically an information-gathering and review function. Information on which to make such a determination must be obtained from each client. This information must then be reviewed to establish the client's eligibility. It is imperative that this function be performed at the time of intake, so that a client profile can be developed along with the application information currently being collected.

Determination of client eligibility should be the responsibility of at least one staff member, preferably an intake counselor or case manager. This individual should become intimately familiar with client eligibility criteria of those alternate funding sources deemed to be relevant to the program. Ideally, one person should be responsible for determining whether or not a client has private medical insurance. If not, the interviewer should: 1) compare the client characteristics data with the client eligibility requirements of the various public third parties, and, if a match can be made, 2) assist the client in applying for assistance from the relevant agency.

KEY REFERENCE SHEET

There are certain key factors which are found throughout the various programs. If one of these factors exists, you should consider, at least, the corresponding programs.

If an individual is:	Consider:
65 years of age or older	Supplemental Security Income Medicare Medicaid Social Services
Blind	Supplemental Security Income Social Security Disability Benefits Social Services
Disabled	Supplemental Security Income Social Security Disability Benefits Medicaid Social Services
Receiving Social Security Disability Benefits	Medicare
Receiving Railroad Retirement	Medicare
Receiving AFDC	Medicaid Social Services Food Stamps
A railroad worker	Railroad Retirement Benefits
A veteran	Federal Veterans Benefits VA Champus
Low Income	Supplemental Security Income Aid to Families w/Dependent Children 51.42 Board Social Services Food Stamps
Unemployed	Unemployment Insurance
62 Years of age or older	Social Security Retirement Benefits Railroad Retirement Benefits

Information to be Obtained in Determining Client Eligibility

The first thing to be determined is whether or not the client has medical coverage.

There are several factors that should be investigated to determine whether or not a client is covered. The following possibilities should be explored (for both new and currently-enrolled clients):

- The client may have private individual insurance (e.g., Blue Cross-Blue Shield, Travelers, Aetna).
- The client may be covered under a policy held by a parent or spouse.
- If the client is employed, he may be covered by a group policy.
- If employment has recently been terminated, the client's group policy may have a conversion privilege to an individual policy.
- The client may be entitled to and receiving benefits from a public assistance program, such as AFDC, SSI, Medicaid, Medicare, Title XX, etc., and thus be entitled to additional benefits as a result of his drug/alcohol problem.
- The client may be enrolled in a Health Maintenance Organization which has contracted with the treatment program to provide services to its enrollees. (See discussion of HMO's.)

In performing this task, it may be necessary to assist the client in determining if any of these (or other) coverage possibilities apply. Here are some suggestions:

- Ask the client to look through wallet, purse, stash bag or whatever to see if there is an insurance card.
- Ask whether a parent, husband, or wife has insurance.
- Let the client call a husband/wife/parent/co-worker to check on whether there is some insurance coverage.
- If the client is employed or has been employed recently, ask if he remembers whether the company insured him.
- Suggest that the client call the employer to find out about coverage from the personnel office.
- Call the family's insurance broker or agent.*
- See if there is a company insurance booklet. Show an example of such a booklet to the client and ask whether he was given a similar booklet by his employer or whether he is aware of anything like it.

* Obtain written permission from the client before making such calls. See Chapter 4 for discussion of confidentiality issues.

- Call the personnel section of the client's employer to determine if he is covered by a group policy and the nature of coverage.*

If, as a result of one or more of the preceding steps, you have determined that the client has health care insurance coverage, the next step is to know such details as: provider eligibility requirements, and services covered. This will usually be provided by the insurance carrier. It is important that if a client has coverage that any and all insurers be billed.

> NOTE: If some or all of the program's services are covered under the client's policy, record this fact along with such data as name and address of underwriter, client's policy number, effective dates of policy, specific type of services covered, and any limitations on the coverage. This data should be maintained so that it is readily assessible to the individuals responsible for billing.

If the client does not have health care insurance, determine his eligibility for benefits provided by one of the publicly financed medical or social service programs. This will necessitate obtaining information regarding welfare status (current welfare recipient or eligible), dependency status, nature and extent of physical/mental handicaps (the latter may require that arrangements be made for formal testing), and other data relevant to state requirements. If the client <u>appears</u> to be eligible for this type of coverage, he should be assisted in applying for the appropriate public assistance. The program may merely provide the client with information on the steps he must take to obtain coverage or actually work with him in doing this. Obviously, there is a practical limit to the actual amount of assistance one can give to any one client. However, some individuals will need more support than others in finding their way through the maze of paperwork and processes that tend to overwhelm the newcomer.

If the client is not eligible for any form of third party reimbursement, a determination should be made (based on program policy) as to whether the client's income level (individual or family) warrants that he be charged for the services provided.

> NOTE: Whatever action is taken regarding reimbursement for services (third party payments, public assistance, 51.42 Board, direct client payment, or no charge), it is imperative that it be recorded and readily available to individuals responsible for billing.

<u>Validation</u>

We have seen that much information needs to be collected regarding clients; a good bit of it goes considerably beyond that which is currently being collected. It may appear to be not only burdensome, but an invasion of (or at least an assault on) privacy. Nonetheless, you not only need to ask for personal information, but verify what you are told. This brings us to the need for validation.

* Obtain written permission from the client before making such calls. See Chapter 4 for discussion of confidentiality issues.

Why Validation?

If your program relies on third party revenue to cover some of its operating costs, accurate client data is imperative in order to provide basic information which will be required by the third party payers. Inaccurate or incomplete client data will certainly complicate, and may preclude, obtaining reimbursement. In the long run, both the program and its clientele suffer.

Means of Validation

Listed below are some techniques for validating personal information:

- Name: Standard identification such as a driver's license, Social Security card, draft card, birth certificate, or marriage license.
- Address: Same as above as well as recently postmarked mail, phone book listing.
- Date of Birth: Birth certificate, driver's license, baptismal certificate.
- Income: Paycheck stub, income questionnaire sent to employer.
- Third Party Insurance: Identification card; contact employer, insurance representative, or welfare agency.

A Word About Confidentiality

There is a problem with confidentiality that is peculiar to substance abuse programs. Normally, a person seeking medical services shows an insurance card, and the treatment facility calls to get forms for treatment and to determine the client's eligibility. In the case of substance abuse, the very telephone call could be, without the client's permission, a violation of his rights of confidentiality. It is also a clear violation of federal law and makes the program staff liable to severe penalties. Even if one calls and does not identify the nature of the problem, the very fact that a facility is known in the community for treating substance abuse problems could violate the confidentiality to which the client is entitled. Therefore, two specific policies are recommended at this stage.

- Do not make a telephone call without the client's written permission and full knowledge that you are going to call and ask for details of his insurance policy. Written permission is mandated by federal regulations. (See section 5, Confidentiality).
- When you make the telephone call, do not discuss the nature of the problem. Just state that the client has come to your facility for medical treatment and you would like details concerning the nature of his coverage and want to have the appropriate forms sent to you.

PROVIDER ELIGIBILITY

Another key issue in third party payments is provider eligibility. This is the acceptance by a third party of a provider as a legitimate source of services for its beneficiaries. Thus, an eligible client must receive services from an eligible provider in order to receive third party reimbursement. In nearly all cases, approval of a facility means that the service provider has met some type of formal credentialing requirement established by either the state, a professional organization, or a recognized accrediting institution. Most third party payers do not attempt to approve or disapprove the eligibility of each individual provider. To do so would be both impractical and beyond their level of expertise. Rather, they accept as eligible those providers who meet standards developed by recognized and acceptable outside sources.

Credentialing

Credentialing is a generic term that encompasses the processes of accreditation, licensure approval and certification. These terms are defined:

> Licensure: The process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title, or grants permission to institutions to perform specified functions. (e.g., H 24 Special Hospitals)
>
> Approval: The process by which an agency or organization evaluates and recognizes a treatment facility as meeting certain predetermined qualifications or standards. It shall apply only to facilities and their services.
>
> Certification: The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association. (e.g., Counselor Certification Board)

SUMMATION

As previously noted, the single most important factor in obtaining third party payments is credentialing. That is, a program must be state-approved and/or accredited before any third party will reimburse it for services provided to its beneficiaries. At minimum, this means having state approval. For many third parties, this will mean some form of accreditation of the program. Accreditation and licensing indicate that a program meets certain operational and physical criteria. But they also often specify that staff members meet certain credentialing requirements. Generally, either key staff members and/or a given proportion of the total staff must be licensed or certified before a program can be credentialed, particularly in the case of accreditation.

What this means to you is quite simple: YOUR PROGRAM AND PROBABLY SOME OF YOUR STAFF MUST BE CREDENTIALED IN ORDER TO OBTAIN THIRD PARTY PAYMENTS. Because there is a precedent for reimbursing physician's services and services provided under a physician's supervision, reimbursement may be easier to obtain if the program employs licensed physicians.

At present, the licensed physician/nonphysician distinction is one of the most significant in terms of third party reimbursement. However, certification and the formal credentialing of other staff is also important and will continue to grow in importance. Therefore, in many cases, success in garnering third party payments will be related to a program's effectiveness in upgrading the technical capabilities of, and subsequently credentialing, its staff.

Remember, the essence of provider eligibility is to prove program legitimacy and quality of care to the third parties. At the present time, this type of proof almost always means credentialing of both the program and its staff.

SERVICE ELIGIBILITY (SERVICES COVERED)

The final key issue in obtaining third party payments is that of service eligiblity, which is formally referred to as services covered. Services covered refers to the types of treatment and services for which a third party will pay, if provided by an eligible provider to an eligible client.

The specific services covered by a third party are spelled out in the insurance policy (if a private payer) or in federal/state rules and regulations governing the payment program (if a public third party). Since wide variations in services covered exist from payer to payer, it is important to identify the requirements of each payer with whom you might be dealing and relate them to the services provided by your program. In this regard, note that although the services covered by a public payer will be uniform for a given state or jurisdicational area, those covered by private payers will vary according to the type of policy held by a client. Thus, in the latter case, it will be necessary to examine the client's insurance policy to determine exactly what services are covered, noting those which correspond with services offered by your program. This information then needs to be recorded for subsequent use by the billing staff.

DETERMINATION OF ELIGIBILITY

This section has discussed the issues of client, provider, and service eligibility. The following section will examine potential third party payers noting, for each, generally applicable criteria with respect to these issues. Additionally, as will be noted in the next section, programs must obtain state-specific and/or company-specific client, provider, and service eligibility criteria, and by comparing these criteria with their own program, service, and client characteristics, determine which third parties are the most relevant to them. Once this has been accomplished, contact should be made with those payers from whom reimbursements will be sought, to initiate their authorization of your program as a provider. The general procedures for obtaining such authorization vary with the provider and are also examined in the following section.

CHAPTER 3

THIRD PARTY PAYMENT MECHANISMS

Third Party Payment Mechanisms

This section discusses those third party payment systems that are most relevant to alcohol and drug abuse treatment programs. This does not mean that any given program can expect to obtain reimbursement from all or even a majority of them; various factors must be considered such as differing provider/client eligibility requirements, the nature of services covered, specific state regulations, etc. However, the systems discussed here represent the most likely sources for reimbursement. Each system is explained and its service, client, and provider eligibility criteria examined. By relating this information to the characteristics of your particular program you will be able to identify which third party payment systems will be most appropriate to your needs. Subsequent efforts can then be expended to obtain further details regarding specific client/provider/ service eligibility requirements of those individual payers who are the most likely potential reimbursers for your program; you can then effect whatever program modifications may be required to meet their eligibility criteria.

The following discussion is divided between federal and private third party payers. The major distinctions between these two groups relate to their financing mechanism, client eligibility requirements (federal eligibility criteria generally limit services to individuals who are economically disadvantaged, physically disabled, or aged and often at no cost to the beneficiaries, while private payers provide coverage on a fee basis only) and basis for operating guidelines (federal and state regulations versus independent company policies).

FEDERAL THIRD PARTY PAYERS

MEDICAID

Medicaid, established in 1965 as Title XIX of the Social Security Act, is a joint federal-state medical assistance program. Federal funds are provided to the states to supplement their own monies according to a formula based on population. The federal share ranges from 50 to 83 percent depending on the state.

Within broad federal guidelines, each state exercises considerable flexibility over who is to be eligible for coverage, what programs or individuals are to be accorded provider status, and what services are to be reimbursable. Each state is required to designate a Single State Agency to oversee the administration of the program. This agency is usually housed within departments of social services, public health, human resources, or some similar department. Each state prepares its own annual Medicaid plan; there are immense variations from state to state in the plans.

Each state must cover those individuals the Federal Government has designated "categorically needy," that is, those individuals who are eligible to receive financial assistance under Title IV A, Aid to Families with Dependent Children (AFDC), and Title XVI, Supplemental Security Income for the Aged, Blind and Disabled (SSI), of the Social Security Act. Those eligible for financial assistance under Title IV A are typically mothers and their dependents. In addition to the aged and the blind, those eligible under Title XVI are

individuals whose disability makes them incapable of gainful employment for at least a year. A diagnosis of alcoholism and/or drug addiction, like any other medical diagnosis, does not automatically render an individual disabled, nor does it automatically make that person eligible for SSI payments. The regulations for the SSI program acknowledge that drug abuse is an impairment which can render individuals disabled. Under the appendix to the regulations, in "Listing of Impairments," alcoholism and drug addiction is listed as follows:

> (12.04) Functional nonpsychotic disorders (psycho-physiologic, psycho-neurotic, and personality disorders; drug addiction and alcoholism). Manifested by marked restriction of daily activities and constriction of interests and deterioration in personal habits and seriously impaired ability to relate to other people and persistence of one of the following:
>
> (12.04A) Demonstrable structural changes mediated through psycho-physiological channels...
>
> or, in another clause:
>
> (12.04G2) Antisocial or amoral behavior manifested by: a) inability to learn from experience and inability to conform with accepted social standards, leading to repeated conflicts with society or authority and b) by psychopathology documented by mental status examinations and the results of appropriate standardized psychological tests...

States may choose to extend coverage to the "medically needy," those individuals and families whose income and resources exceed the standards defining the "categorically needy" but are nonetheless insufficient to meet the cost of necessary medical care. The Federal Government has defined two types of "medically needy." The first type is the "categorically related medically needy," i.e., those individuals who would otherwise qualify as "categorically needy" except for their additional income and resources. The second type is the "noncategorically related medically needy" who would not qualify as "categorically needy" because they do not meet both the nonfinancial and financial criteria.

If a state chooses to extend coverage to the "categorically related medically needy," the Federal Government will provide matching funds at the same rate as for the coverage of the "categorically needy." It will not provide funds for coverage for the "noncategorically related needy." Thirty States have elected to cover the "categorically related medically needy"; four States cover the "noncategorically related medically needy."

The Medicaid statute specifies certain services which it is mandatory for the states to provide. They include:

- Inpatient hospital services, other than services in an institution for tuberculosis or mental disease
- Outpatient hospital services
- Other laboratory and X-ray services

- Skilled nursing facility services, other than services in an institution for tuberculosis or mental disease; early and periodic screening, diagnosis, and treatment of physical and mental defects in eligible people under 21; and family planning services

- Physicians' services rendered in the office, patient's home, hospital, skilled nursing home, or elsewhere.

Other services listed in the statute are optional. The most important optional service for alcohol and drug abuse programs is probably clinic services. Other optional services of possible significance to alcohol and drug abuse programs are:

- Other diagnostic, screening, preventive, and rehabilitative services

- Inpatient H24 rehabilitation hospital services

- Any other medical care and any other type of remedial care recognized under state law and specified by the Secretary.

The Medicaid program is oriented toward financing traditional medical care, and therefore there is a tendency not to cover services unless they are delivered or supervised by a physician. Thus, social services are seldom covered, even when they are provided under the supervision of a physician as an ancillary part of the treatment regimen. Likewise, rehabilitation services are less likely to be reimbursable than direct medical services.

Providers of medical services--such as physicians, hospitals, intermediate care facilities--must be officially accorded provider status by the state agency overseeing the Medicaid program in order to receive Medicaid payments. Medicaid has its own certification procedures distinct from any other state licensing requirements, although state licensing and/or accreditation is also generally required of providers.

A methadone treatment program might be accorded "clinic" status. Clinic services are reimbursed by the state. Other possible categories might be skilled nursing home and intermediate care facility. If a program cannot fit under any of these various provider categories, physicians or psychiatrists who treat clients of the program could bill for services.

Client Eligibility

There are three categories of individuals who are eligible for Medicaid:

1. Categorically Needy

   Individuals who qualify for cash assistance under one of the following programs, whether or not they are actually receiving such assistance:

   - Title IV-A of the Social Security Act (cash assistance to families with dependent children);

- Title XVI of the Social Security Act (Supplemental Security Income "SSI" for the Aged, Blind, and Disabled); and

- A state program supplementing Title XVI.

Coverage for all individuals falling into one of the above categories is mandatory, and federal financial assistance is provided on the basis of the aforementioned formula.

2. Categorically Related Medically Needy

Individuals who meet the nonfinancial requirements of the Categorically Needy but whose income and resources* exceed the maximum allowed for that category, but are still not sufficient to permit them to meet the costs of necessary medical services.

Coverage for this category of recipient is optional; however, if a state selects this option, federal financial assistance is provided on the same basis as for the Categorically Needy.

3. Non-Categorically Related Medically Needy

Individuals who do not meet either the financial or nonfinancial eligibility criteria established for the Categorically Needy (see above) but who are deemed, by the state, to lack sufficient income to pay for necessary medical services. Since no federal monies are available for this category, states have complete freedom in defining the eligibility criteria.

Additional federal requirements regarding client eligibility criteria relate to age, income, and state residency.

Age: Any individual 65 years or older, and child under 21 who is classified as a "dependent child" under AFDC, must be covered.

Income: Income requirements are established by the state and, therefore, vary considerably.

State Residency: All residents of a state must be covered regardless of length of residency.

What this means is that, for the most part, client eligibility for Medicaid is limited to:

1. Children of AFDC recipients who are under 21 years of age;
2. Individuals who are 65 years of age or older;
3. Individuals who are blind; and

* "Resources refers to tangible assets owned by an individual such as stocks and bonds, life insurance, jewelry and other personal property (generally, only if in excess of a specified amount), etc. The specific items considered as "resources" will vary from state to state.

4. Individuals who are disabled (i.e., unable to work for a period of one year). Some alcoholics and drug addicts, in some states, may qualify as "disabled" due solely to their alcoholism and drug addiction. In other instances, an addict can qualify if he is considered to be disabled due to a second impairment. A third possibility is that an addict having an additional impairment may qualify on the basis that the combined effect of both impairments renders him unemployable.

Provider Eligibility

The specific eligibility requirements for both institutional providers (e.g., hospital, skilled nursing facility, intermediate care facility, clinic) and individual providers (e.g., physician, health care technician) are determined by the state. Approval by a state credentialing body is required for both institutional and individual providers. The services rendered by a provider must meet the state's definition of "medical or remedial services." Individual providers may be physicians, other practitioners licensed as medical practitioners by the state, or health care technicians (i.e., individuals who meet federally approved proficiency qualifications as opposed to educational, professional, or other formal criteria).

Specific types of requirements that institutional providers must meet relate to factors such as: 1) health, 2) humane treatment, 3) sanitation, 4) physical facilities (including type of construction, space, and accommodations per person), 5) fire and safety, 6) staffing (number and qualifications), 7) client records, and 8) administrative and fiscal arrangements.

In addition, many states require a formal contract or purchase of services agreement with a provider. In all cases, a provider must obtain a vendor number to be used in submitting bills for services to the Medicaid authority.

There are two types of institutional providers (other than hospitals) which a state may approve for Medicaid that may be particularly applicable to alcohol drug abuse treatment programs. These are:

- Clinics: Defined as facilities that are not part of a hospital but organized and operated to provide medical care to outpatients.

- Intermediate Care Facilities (ICF): Defined as an institution licensed under state law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) that can be made available to them only through institutional facilities.

Generally, treatment programs are more likely to fall under the category of "clinics" than of an ICF.

Once approved as a provider, a facility may be subject to the following requirements:

- Financial records are subject to periodic audit, and financial reports may be required, by the state Medicaid authority.

- Inpatient care (in short-stay hospitals) must be certified as medically necessary and must be periodically reevaluated during the extent of the patient's stay. This process, known as concurrent review, will eventually extend to all providers and become the responsibility of the Professional Standards Review Organization (PSRO) in each of 203 areas around the country.

Where a program does not meet the Medicaid eligibility criteria, individual providers (e.g., physicians, laboratory technicians, etc.) operating within the facility may be able to collect individually for the services they render to clients. Where this type of arrangement is used, Medicaid reimbursement must be made directly to the individual services provider unless the provider is required to turn over his fees to the program or a contractual arrangement has been made between the provider and the program permitting the latter to submit all bills for service.

Obtaining Provider Status

Participation in the Medicaid program requires that a provider be certified by the state Medicaid authority as meeting its eligibility criteria and a formal agreement entered into between the provider and the Medicaid authority. Generally, certification for Medicaid participation requires the following:

1. Contact the Director of the Bureau of Health Care Financing, Division of Health to obtain its requirements for participation and an application form for participation.

2. Review the requirements for participation and determine if your program meets all mandatory requirements. Note: Some requirements might be specified as "should" or "desirable" as opposed to "must." Although probably not mandatory, these requirements increase the likelihood of certification, and, therefore, should be met if possible.

3. If your program does not currently meet all of the mandatory requirements, you must decide whether to implement the modifications necessary to meet these, or not attempt Medicaid certification.

4. The next step, if you are pursuing Medicaid certification and believe that you meet the state's requirements, is to complete the application and submit it, along with any other required materials, to the Medicaid authority.

5. The Medicaid authority will then review your application. If your application is acceptable, an on-site inspection of your facility may be made to verify compliance with its requirements.

6. If your application is rejected or your facility does not pass the on-site inspection, you will be notified, and the shortcomings identified. You will have an opportunity to take the necessary actions and reapply.

7. If your program is certified for participation, you will have to enter into a formal agreement with the state Medicaid authority. The specific nature of this agreement generally includes conditions relating to maximum charge for services, willingness to abide by the Medicaid regulations, and accessibility of financial and other records. (See provider contract following pages)

Reimbursement

States are required to set maximum limits on reimbursement for each type of service covered. Thus, a provider cannot be reimbursed more than the upper limit but may receive less, depending on the basis for reimbursement and/or the actual cost to the provider.

Medicaid regulations stipulate that hospitals be reimbursed for inpatient care on the basis of "reasonable cost." Other service providers may be reimbursed according to state policies. However, federal regulations recommend that reimbursement be based on reasonable cost and stipulate the means (e.g., customary charges) for determining the upper limit for various types of services. Generally, the upper limits are established on the basis of "reasonable cost" or "reasonable charge."

- Reasonable cost: The actual cost of providing a service. However, the cost must be in line with costs of similar providers in the same locality for the same service.

- Reasonable charge: Generally based on "customary charges" or "prevailing charges."

  - Customary Charge: The charge that a particular provider usually makes for a given service. If no one amount is charged to the majority (75%-80%) of clients, the median charge is normally used.

  - Prevailing Charge: A charge that lies within the range of charges that are most common within an area (i.e., a political or economic subdivision of a state).

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF HEAL
MAIL ADDRESS: P. O. BOX 309
MADISON, WISCONSIN 53701

IN REPLY PLEASE REFER TO:

TO: All Medicaid Provider Applicants

FROM: Martin A. Preizler, Director
Bureau of Health Care Financing

DATE: December 15, 1977

RE: Medical Assistance Program Policies -- General Overview

Introduction

This fact sheet will give you a broad outline of the more important policy areas--other than specifics on covered services, billing and reimbursement--in the Wisconsin Medical Assistance program. While it highlights most major policy areas, it does not deal with all MA policy. If you seek additional information on any policy areas, please contact the Bureau of Health Care Financing.

I. General Policies Providers Must Follow

A. MA Card. Providers should require that all Medical Assistance recipients present their MA card each time services are provided. (Laboratories, blood banks and those other providers not having face-to-face contact with recipients should obtain eligibility information from the provider referring the patient). Eligibility dates are listed on the card. They should be checked carefully each time a recipient is seen. The recipient must be eligible for Medical Assistance on the day services are provided or MA will not pay for the services.

B. Records. Providers must keep records documenting services to recipients, including type of service, dollar amount, dates of all transactions, and medical records, prescriptions and any other records as are necessary to fully disclose the nature and extent of services provided under the MA Program. Records must be kept at least 6 years from the date of payment. Providers are required to make all records regarding MA recipients available to authorized Department of Health and Social Services personnel for inspection upon request. In the event that the Provider's participation is terminated for any reason, all records shall remain subject to the conditions of this paragraph.

C. Reimbursement For Services Via Third Party Sources. Providers, prior to rendering services, should take all reasonable steps required to ascertain whether the patient has insurance other than MA (such as Medicare) which would cover the cost of such services. Wisconsin Statute 49.47(6)(c)(2) prohibits the Department from making payment for services where reimbursement is payable through any federal, state, county or private coverage to which the beneficiary may be entitled. In addition, if you believe that the patient's illness or injury is the result of an accident, indicate this on the claim form so the MA program can pursue coverage that might result from third-party liability.

D. Prior Authorization. Providers are required to seek Department authorization for certain specified services prior to initiating service delivery. Any claim for a service which requires prior authorization will not be reimbursed

unless a copy of the authorization document has been submitted to the fiscal agent with the first reimbursement claim and the recipient is eligible during the date(s) of service. For a list of those services which require prior authorization, see the MA bulletin for your provider type.

E. Regulations on Participation. Providers participating in the Medical Assistance program must comply with the requirement of the "Civil Rights Act of 1964" which provides in part that:

> No person in the United States shall, on the grounds of race, color or national origin be excluded from participation in, be denied benefits of, or be subject to discrimination under any program or activity receiving federal financial assistance.

Federal regulation 42 CFR 450.30(a) (8) states "...that participation in the (Medicaid) program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure." Therefore, a provider must accept reimbursement from the program as payment in full for services and items furnished under the program and is precluded from seeking additional or supplemental payment from a Medical Assistance recipient for services provided and paid for under the program. Since payment and satisfaction of claims are from federal and state funds, any false claims, statements, documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

F. Applicable Laws. A provider must comply with federal laws and regulations related to Title XIX of the Social Security Act as well as state laws and administrative rules pertaining to the Medical Assistance program. The Department is in the process of preparing and will furnish a Provider Handbook which summarizes provider program participation requirements as well as identified Departmental policies. Such handbooks will be periodically updated to reflect program changes affecting provider participation.

G. Resolutions of Questions. Questions concerning claim forms, expected time of payment and explanation of remittance advices should be directed to the fiscal agent:

E.D.S. Federal
6406 Bridge Road
Madison, WI 53713

Local: (608) 221-4746
In-State Toll Free: 1-800-362-9111

Questions concerning interpretation of state policy and bulletins may be addressed to:

Bureau of Health Care Financing
1 W. Wilson Street, Room 325
Madison, Wisconsin 53702
(608) 266-9745, 266-9746, or 266-9744.

Inquiries about prior authorization status may be directed to (608) 266-2521. Recipients may call (608) 266-9745 collect. Providers may call (608) 266-9746 or 266-9744.

WISCONSIN MEDICAL ASSISTANCE

PROVIDER CONTRACT

This agreement, by and between the Department of Health and Social Services and _____, a Provider of health care services, sets forth the terms and conditions under which the Provider shall perform and be reimbursed for services under the Wisconsin Medical Assistance Program, administered by the Department of Health and Social Services.

1. Provider shall comply with all federal laws and regulations related to Title XIX of the Social Security Act, and all State statutes and administrative rules pertinent to the Wisconsin Medical Assistance Program, as are now in effect or as may later be amended. Provider does not by virtue of executing this agreement waive any rights to contest the validity of any existing or future federal or state laws, regulations or administrative rules.

2. The Department and Provider mutually agree that reimbursement to the Provider for services and items furnished by Provider pursuant under the Program shall comply with federal and state laws, regulations and administrative rules, as are now in effect or as may later be amended. The Department has established the Provider payment schedule entitled "Terms of Provider Reimbursement", attached hereto and incorporated herein by reference, and agrees to reimburse Provider for services and items properly rendered under the Program in accordance with said schedule. Provider agrees to accept such reimbursement as payment in full for services and items furnished under the Program and agrees not to seek or retain any additional payment from the recipient of such services or items for services or items provided and paid for under the Program. In the event that the Department desires to change or modify the attached reimbursement schedule it shall accord Provider notice of such intent and the opportunity for input into the reimbursement processes utilized to effect such change.

3. Provider agrees to submit claims for reimbursement on forms prescribed and supplied by the Department. The Department shall furnish the Provider instructions for proper completion and submission of claims. The Department shall pay all claims for authorized service, properly completed and submitted, within 60 days.

4. The Department may recover the amount of any improper or excessive payment made to the Provider by deducting the amount of such improper payment or such excess from future amounts owed the Provider under the Program. The Department shall, prior to making any deduction, give the Provider written notice of its intent to deduct which sets forth the amount of the intended deduction and identifies the reasons therefore. If the Provider desires to contest the propriety of the proposed deduction, the Provider shall, within ten (10) working days after receipt of the Department's notice of intent to deduct, request a hearing on the matter. Such a request shall be in writing and shall briefly identify the Provider's basis for contesting the deduction. Unless a timely request for hearing is received the Department may deduct from future amounts owed the Provider those amounts specified in its original notice. Receipt of a timely request for hearing shall preclude the Department from making any deductions during the pendency of the hearing proceedings. Proceedings to resolve a contested deduction shall be in accordance with Chapter 227 of the Wisconsin Statutes. All notices required to be given shall be in writing and shall be conclusively presumed to have been received within three (3) days after evidence of mailing.

5. In the event the Provider receives payment from a third-party source for services or goods furnished for which the Provider has received payment under the Program, the Provider shall within thirty (30) days reimburse the Department or promptly notify the Department to deduct the appropriate amount from payments owing the Provider under the Program.

6. The Provider agrees to prepare and maintain such records, prescribed by the Department, as necessary fully to disclose the nature and extent of services or supplies provided by the Provider under the Program. The Provider shall grant the Department access to such records upon request. Provider agrees further to permit official Department and Federal personnel access at all reasonable times to Provider's program payment records as well as the medical records of medical assistance recipients to whom such payment records relate. Department personnel shall have proper identification as authorized in writing by the Administrator, Division of Health. All records shall be retained by Provider for a period of not less than six years from the date of payment by the Department for the services rendered. In the event that Provider's participation in the Program is terminated for any reason all records shall remain subject to the conditions of this paragraph.

7. Provider agrees to comply with the "Civil Rights Act of 1964", any amendments thereto, and all rules and regulations promulgated thereunder.

8. Provider may terminate this agreement upon thirty (30) days' written notice to the Department. The Department may terminate or suspend the Provider's participation if the Provider engages in conduct or practices which by Departmental rule constitutes grounds for termination or suspension. Proceedings to terminate or suspend Provider's participation in the Program, or any proceedings resulting from the decision by the Department not to renew the agreement, shall be in accordance with Chapter 227 of the Wisconsin Statutes and applicable federal laws. Further, in the event of a change of ownership this agreement shall automatically terminate, except that Provider shall continue to maintain records required by paragraph 6, unless an alternative method of providing for maintenance of such records has been established in writing and approved by the Department.

9. In the event that Provider determines that in order to assure quality health care to a recipient of medical assistance it will be necessary to provide services or items beyond those authorized under the Program, nothing in this agreement shall preclude the Provider from furnishing such services or items provided that Provider, prior to rendering such services or items, advises the recipient that such services or items are not reimbursable under the Program, and that all costs associated with the furnishing of such services or items shall be borne by the recipient and not by the Program.

10. This agreement shall, unless terminated as provided herein, remain in full force and effect for one (1) year from date of execution. For purposes of the paragraph this agreement shall be deemed to have been executed on the date set forth below, that being the date on which it was signed on behalf of the Department by its authorized representative. In the absence of a notice of termination by either party, the agreement shall automatically renew and be extended for periods of one (1) year.

IN WITNESS WHEREOF, the parties hereto have set their hands and seals this _____day of _____, 19__.

PROVIDER

_____
(Typed or Printed Name of Provider)

_____
Address

By:_____
Signature of Provider or Authorized Agent

_____
Title

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

By:_____

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THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

TITLE XIX PROVIDER PROFILE

Definition.

Controlling Interest. "Controlling interest" includes, but is not limited to those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage interest holders, employees or stockholders with holdings of 10% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

1. List all types of Medicaid services you provide, e.g., emergency transportation, psychiatric counseling, physician-general practice, pharmacy services, etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. Do you affirm, as required by state regulations, that neither you nor any employee, nor person in whom you have a controlling interest, nor any person having a controlling interest in you, have, during the preceding five years, been convicted of a crime related to, or terminated from federal or state medical assistance programs?

Yes_____ No_____

If no, explain. _____

_____

_____

_____

_____

3A. Do you, the applicant have a controlling interest in any vendors of the special service categories identified below?

Yes_____ No_____

If yes, identify each special service category and the general type of controlling interest as defined in the above definition.

Special Service Category	Type of Controlling Interest
_____drugs	_____
_____medical supplies	_____
_____transportation	_____
_____visiting nurse and/or home health agency service	_____
_____providers of any type of therapy	_____

3B. Does any person and/or entity have a controlling interest in any of the Medicaid services you provide?

Yes_____ No_____

If yes, to any Part A or Part B of question Three, complete question Four, Five A and Five B.

4. Are all of the services provided by you and any special service vendors in which you have a controlling interest billed under a single provider number? (Excluding physicians with multiple clinic practices)

Yes_____ Number_____

No_____

5A. List the names and address of all persons/entities with a controlling interest in you, the applicant. (If necessary, attach additional sheets, using same format as below)

Type of Interest

Name: _____ _____
Last First MI

Address_____ _____
Street

_____ _____
City State-Zip

Social Security Number or_____ _____
IRS Tax Number: _____
Provider Number, if _____ _____
applicable.

Type of Interest

Name _____ _____
Last First MI

Address _____ _____
Street

_____ _____
City State-Zip

Social Security Number or _____ _____
IRS Tax Number: _____
Provider Number, if _____ _____
applicable.

5B. List the names and addresses of all vendors of special services in which you have a controlling interest. (If necessary, attach additional sheets, using same format as below)

Type of Interest

Name _____ _____
Last or Corp. First MI

Address _____ _____
Street

_____ _____
City State-Zip

Social Security Number or _____ _____
IRS Tax Number: _____
Provider Number, if _____ _____
applicable.

Name _____ _____
Last or Corp. First MI

Address _____ _____
Street

_____ _____
City State-Zip

Social Security Number or _____ _____
IRS Tax Number: _____
Provider Number, if _____ _____
applicable.

I affirm that the above statements and any attachments are correct to the best of my knowledge. I further affirm that I will notify the department of any changes in the above within thirty (30) days of such changes.

_____ _____
Signature Date

A provider's initial effective date with Wisconsin's Medical Assistance Program cannot precede the date that notification of intent to provide services is received. The notification may come in any of several ways:

1) Telephone request for a number

2) Written request for a number

3) Unsolicited information form

4) Rejected claim form (see Problems with Initial Effective Date procedure)

Establishing the date of receipt (whether at the State or fiscal agent's office) is important. If date of receipt is not discernable, the date of receipt will be considered as the date material was mailed to applicant. If there is no record of that, then 5 days after the date of letter or date on information form will be used.

The date of receipt as determined above will be the initial effective date only if the following are met:

1) The information form is returned along with additional required material within 30 days of application request.

2) All criteria are met as of the date of application (licensure, degree, registration, etc.)

3) Applicant does not indicate that he will begin practicing in the future. (e.g., applicant states his practice will be open one month in the future.)

Otherwise the initial effective date is the earliest date all the criteria are met.

Clinic Numbers

Clinic Numbers (identified by the prefix "C") will be assigned to groups who have clinic pricing profiles. This will allow the group to receive one check and one remittance advice form for any number of performing providers. Pricing will always be derived from the Clinic Number (the billing provider). However, the performing provider will be carried and reported when system updates can be made to allow this.

All Clinic Numbers will be loaded on the Master Provider File as group record types; this will allow the provider numbers of the individual members to be listed on the group record.

Individuals who practice in two locations and who need to receive their payments separately, according to profile or individual pricing guidelines, will be assigned a regular provider number for certification purposes and a Clinic ("C") Number for each location. Pricing will be derived from the Clinic Number, rather than the individual number. The individual number will be listed on the group record (the Clinic Number) for reference.

Use of the Clinic Number

1. The Clinic Number will be entered on the claim in the header area.

2. Detail level performing provider will be required, but pricing will be derived from the clinic pricing profile.

3. One check and one Remittance and Status Report will be generated for payment of claims.

4. A letter explaining procedures for using Clinic Numbers will be sent to all providers assigned "C" Numbers.

SUPPLEMENTAL SECURITY INCOME (SSI)

Established in 1973, the SSI program was designed to replace state-operated federally assisted welfare programs for the aged, blind, and disabled. The program entitles eligible persons to monthly cash payments to cover subsistence expenses.

To qualify as "disabled" for purposes of eligibility under SSI a person must have a medically determined physical or mental impairment that would render him/her incapable of being gainfully employed for at least one year. Drug addiction and/or alcoholism per se does not automatically qualify an individual for SSI. However, depending upon the severity of the addiction/alcoholism or whether the addiction/alcoholism is in combination with other impairments a judgment may be made that the person is unable to perform gainful employment for at least one year, and is thus eligible for SSI.

Each disability case turns on its own merits, thereby making generalization hazardous. The ability to engage in substantial gainful activity is measured on the basis of the claimant's particular capabilities, severity of impairment, and his/her subjective symptoms; the claimant is viewed as a whole, with age, ability, education and work experience taken into consideration.

Drug abusers are required to receive payments through a representative payee. The SSI recipient may elect to have his/her payments made to the treatment program as representative payee.

A disabled person under age 65 who is a drug addict or alcoholic must accept appropriate treatment, if available, if the drug addiction or alcoholism is a contributing factor to his/her disability.

Basic SSI Eligibility Requirements

The definitions of aged, blind, and disabled, as applied under the supplemental security program, are as follows:

A. Aged

A person must be age 65 or over to be considered aged for supplemental security income purposes.

B. Blind

An individual is considered blind under the SSI program if the vision in his better eye is 20/200 or less with the use of a correcting lens, or if he suffers from tunnel vision to the extent that his field of vision is no greater than 20 degrees (this is the same definition of blindness used in the social security disability insurance benefits program).

A 3-month adjustment period applies in the case of medical recoveries; i.e., payment continues for two additional months after the month of recovery. The ability of a blind recipient to engage in substantial gainful activity does not affect his eligibility to SSI.

C. Disabled

The SSI definition of disability is the same as the one used in the social security disability insurance benefits (DIB) program - an inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Functional Nonpsychotic Disorders (Alcoholism - Drug Abuse)

(Psychophysiologic, psychoneurotic and personality disorders, drug addiction and alcoholism). Manifested by marked restriction of daily activities and constriction of interests and deterioration in personal habits and seriously impaired ability to relate to other people and persistence of ONE of the following:

A. Demonstrable structural changes mediated through psychophysiological channels (e.g., duodenal ulcer); OR

B. Recurrent and persistent periods of anxiety, with tension, apprehension, and interference with concentration and memory; OR

C. Persistent depressive affect with insomnia, loss of weight, and suicidal ideation; OR

D. Phobic or obsessive rumination with inappropriate, bizarre, or disruptive behavior; OR

E. Compulsive, ritualistic behavior; OR

F. Persistent functional disturbance of vision, speech, hearing, or use of a limb with demonstrable structural or trophic changes; OR

G. Long-lasting, habitural, and inappropriate patterns of behavior manifested by one of the following:

1. Seclusiveness and autistic thinking; OR

2. Antisocial or amoral behavior (including pathologic sexuality) manifested by: (a) inability to learn from experience and inability to conform with accepted social standards, leading to repeated conflicts with society or authority and (b) by psychopathology documented by mental status examination and the results of appropriate, standardized psychological tests; OR

3. Pathologically inappropriate suspiciousness or hostility manifested by psychopathology documented by mental status examination and the results of appropriate, standardized psychological tests.

Other Eligibility Factors

A. Residency and Citizenship

An individual must be a resident of the United States (defined as the 50 States and the District of Columbia) and be either a U.S. citizen (including U.S. nationals) or an alien lawfully admitted for permanent residence or otherwise legally residing in the United States for 30 consecutive days to establish eligibility. Recipients who are outside the U.S. for an entire calendar month lose their eligibility for such a month. Any individual who has been outside the United States for 30 consecutive days or more must again reside in the United States for at least 30 consecutive days to reestablish eligibility.

B. Must File for Other Benefits

To be eligible for supplemental security income, an individual must file for all other benefits to which he may be entitled (such as social security, workmen's compensation, private pensions, and veteran's benefits). He must file for other potential benefits (generally within 30 days) after being notified in writing by SSA of potential eligibility for the other benefits, and actively pursue the claims.

C. Vocational Rehabilitation and Treatment

A blind or disabled individual under 65 is required to accept the vocational rehabilitation services made available to him. If he refuses without good cause to accept those services, he will be precluded from eligibility. To remain eligible, a disabled individual who is medically determined to be a drug addict or alcoholic must accept appropriate treatment in an approved facility (if available), cooperate with the required testing program, and demonstrate that he is complying with the requirements for the treatment. If he does not, he will be precluded from eligibility. Participants in the treatment program will be monitored to assure their compliance with the program and to determine the extent to which the treatment is contributing to the purposes of the program. This provision does not apply to individuals receiving payments based on age or blindness.

D. Institutionalization

No person will be eligible for SSI payments for any calendar month throughout which he is an inmate of a public institution unless:

1. Such public institution is a facility approved for Title XIX (Medicaid payments), and

2. Such public institution is receiving Title XIX payments on behalf of such person, and

3. The amount of such Title XIX payments represents more than 50 percent of the cost or charges (whichever is lower) in treating and/or maintaining such a person.

If the above conditions are met, the individual is eligible for a reduced standard payment of $25, reduced by any countable income.

A public institution is an institution that is operated or administered by a governmental unit. This could be a Federal, State, city, county, or other political subdivision. Included as public institutions are prisons, hospitals, nursing homes, etc.

Residence or confinement in a nonpublic institution does not make a person ineligible for SSI payments but may affect the standard of payment (i.e., reduce it to $25) if Title XIX funds are maintaining such a person.

VOCATIONAL REHABILITATION (VR) SERVICES

Vocational Rehabilitationn is a state/federal program located within the Wisconsin Department of Health and Social Services. Operating under the Rehabilitation Act of 1973, the Division of Vocational Rehabilitation places emphasis on improving the employability of physically and mentally handicapped persons, including alcohol and drug abusers. The more severely handicapped are the target group.

Goals of vocational rehabilitation are met through intensive casework including vocational counseling, diagnostic evaluation and job placement services. These are provided by a professional vocational rehabilitation counselor directly to the handicapped person. Among the other activities are eligibility determination, intensive diagnostic studies, vocational evaluation, and career assessment. For each handicapped person an Individualized Written Rehabilitation Program is developed which may including training (college, university, vocational/technical, on-the-job training, rehabilitation facility, or other specialized training), restoration (both physical and mental), occupational tools and licenses, prosthetic devices, and supportive maintenance and transportation.

Acceptable outcomes to vocational rehabilitation services are competitive employment, sheltered employment self employment, homemaking, and family worker. Job placement services are viewed as an intregal part of the total process.

Eligibility for vocational rehabilitation consists of (1) the presence of a physical or mental disability which for that individual constitutes or results in a substantial handicap to employment, and (2) a reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability.

Most referrals of alcohol and drug abusers in Wisconsin come through coordinated efforts between vocational rehabilitation field offices and community 51.42 Boards, treatment facilities, and half-way houses. In some areas DVR provides a specialist in alcohol and drug abuse to work with resources. Other areas are covered by vocational rehabilitation counselors having a specific liaison responsibility.

The referral of potentially eligible alcohol and drug abusers is encouraged through vocational rehabilitation field offices.

Classification of Disability Conditions and Causes

The DVR Alcoholism/Drug Abuse Subprogram Advisory Committee met on July 15, 1975, to develop definitions and guidelines to be utilized in classifying alcoholics and drug addicts as to the severity of their disability. The definitions that were developed were comparable to those developed by staff in the RSA Office in Washington for the psychotic and psychoneurotic.

The attached definitions include specific descriptions of the mild, moderate and severe alcoholic and drug addict. Furthermore, specific guidelines are attached under these three headings: mild, moderate and severe.

The counselor should use both the definitions and the guidelines in preparing written documentation for the client's casefile that supports the counselor's judgment that the client is either severely disabled or non-severely disabled.

If the client falls within the definition of a moderate or severe alcoholic or drug addict, he should be classified as severely disabled. It is anticipated that very few clients who are defined as severe will be feasible for DVR services. To be labeled as moderate which would require the classification of severely disabled, the alcoholic or drug abuser must have documentation in his casefile that would label him as a moderate in at least two of the four discrete areas (physiological symptoms, drinking history, psychosocial, vocational): and they must include drinking or substance abuse history and vocational.

ALCOHOLISM

MILD: The excessive use of alcohol in order to cope with the stresses of daily living without substantial loss of personal, economic, or social efficiency. With provision of vocational rehabilitation services, can maintain an adequate level of personal and social adjustment and engage in competitive employment. Able to accept direction, can maintain adequate interpersonal relations and concentrate sufficiently to meet the requirements of the job. Only in occasional situations of particular internal, social or economic stress would require supervision, guidance or support after placement.

MODERATE: The excessive use of alcohol that results in substantially reduced ability to cope with the stresses of daily living. Modification in patterns of daily living due to inadequate personal, social and vocational adjustment. Can adequately maintain himself in the community and in competitive employment in low stress situations with the provision of vocational rehabilitation services. May require continuing supervision, motivation and support for a reasonable period of time after job placement. May occasionally fail to maintain sobriety during the rehabilitation process and after job placement, which may result in moderate levels of interference with job performance and relationships with other employees.

SEVERE: Excessive uncontrolled use of alcohol as the means of dealing with the stresses of daily living. Presence of multiple physical problems related to the excessive use of alcohol for prolonged periods of time. Inability to engage in competitive employment on a regular basis. Capable of only marginal or sheltered employment under sheltered conditions on a regular basis. Inability to maintain stable relationships in family or community, resulting in loss of family and social isolation. Disruptive behavior, loss of interest in normal activities of daily living, general financial problems due to chronic unemployment or marginal or substantial under-employment. Problems with memory and concentration will be evident in counseling sessions, which will necessitate guidance, supervision, and support by staff during the rehabilitation process. Poor eating and personal hygiene habits may contribute to health problems.

ALCOHOLISM

	MILD	MODERATE	SEVERE
Physiological Symptoms	None	Occasional blackouts, minimal liver damage, minor symptoms of withdrawal, e.g., tremors, gastritis	Frequent blackouts, severe withdrawal symptoms (e.g., DTs, severe liver damage, damage to central nervous system, (brain damage)
Drinking History	No history of inpatient treatment for alcoholism. Short duration of problem drinking (3 yrs. or less).	History of inpatient treatment for alcoholism. One admission. Three to seven years of problem drinking.	History of inpatient treatment for alcoholism. Two or more times and/or detoxification. More than seven years of problem drinking.
Psychosocial	Evidence of stress in relationships with members of family and peers. Erratic behavior associated with drinking. Unexplained absences from home, binge drinking, neglect of children, denial of severe drinking problem.	Evidence of marital and/or family problems alcohol related financial problems. History of arrests for alcohol related offenses or one arrest and conviction. Evidence of depression.	Divorced or separated. History of two or more convictions for offenses related to alcoholism/ social isolation, indigence, or poverty level existence. Evidence of severe and and chronic depression.
Vocational	Employer warnings re: absenteeism or tardiness related to drinking. Decline in productivity. Problems in getting along with fellow employes. Drinking during work hours, i.e., during lunch periods, coffee breaks.	Drinking on the job. Frequent absences from work. Disciplinary actions include suspension or dismissal from job. History of job losses, due to drinking. Frequest movement from one job to another voluntarily. (at least one job change a year for 5 years or more).	Chronically unemployed. Marginal employment. Frequent job loss due to drinking (i.e., loss of three jobs or more in one year. Substantially underemployed.

DRUG ADDICTION

MILD: The intentional use of a chemical substance with mind-altering effects for non-medical purposes, that interferes to a significant extent with the individual's psychological functioning, social adaptation, and educational or vocational adjustment. With the provision of vocational rehabilitation services can maintain an adequate level of personal and social adjustment and engage in competitive employment. Able to accept direction, can maintain adequate interpersonal relations and concentrate sufficiently to meet the requirements of the job. Only in occasional situations of particular internal, social, or economic stress would require supervision, guidance or support after placement.

MODERATE: Frequent and habitual use of a chemical substance which has mind-altering effects for non-medical purposes in a manner which interferes to a substantial degree with the individual's psychological functioning, social adaptation and educational or vocational adjustment. Noticeable and significant adverse effects on the individual's health and physical functioning are evident. The excessive use of drugs that results in substantially reduced ability to cope with the stresses of daily living. Modification in patterns of daily living due to inadequate personal, social and vocational adjustment. Can adequately maintain himself in the community and in competitive employment in low stress situations with the provision, motivation and support for a reasonable period of time after job placement. May occasionally fail to maintain himself in a drug-free state during the rehabilitation process and after job placement, which may result in moderate levels of interference with job performance and relationships with other employees.

SEVERE: Frequent and habitual use of a chemical substance which has mind-altering effects for non-medical purposes for a prolonged period of time, in a manner which has resulted in both physical and psychological dependence so that the individual is incapable of functioning in activities of daily living without the continuous use of the chemical substance. Presence of physical problems affecting the central nervous system, resulting in symptoms of withdrawal when the use of the chemical is discontinued. Inability to engage in competitive employment on a regular basis. Inability to maintain stable relationships in family or community, resulting in loss of family and social maladjustment. Severe financial problems due to the need to purchase expensive drugs on a regular basis, combined with limited income from sporadic or marginal employment.

DRUG ADDICTION

	MILD	MODERATE	SEVERE
Psyciological	None	Minor symptoms of withdrawal (e.g., nausea, irritability). Tolerance to a limited extent.	Severe symptoms of withdrawal (cramps, chills, vomiting). Loss of appetite, loss of weight. Tolerance to the point of needing increased doses to maintain the same effect.
History of Drug Abuse	No history of any type of treatment.	History of outpatient treatment for drug abuse.	History of inpatient treatment for drug abuse, including therapeutic community. Detoxification on inpatient or outpatient basis. Pattern of drug abuse for two or more years. History of methadone treatment or currently involved in a methadone program.
Psycho-Social	Evidence of stress in relationships with family members and peers, erratic behavior associated with drug abuse. Unexplained absences from home, neglect of children, denial of drug abuse.	Evidence of marital and/or family problems, drug abuse related financial problems. History of arrests for drug related offenses or one arrest and conviction. Evidence of anxiety and depression.	Divorced or separated. History of two or more convictions for offenses related to drug abuse-social isolation, indigence or poverty level existence. Evidence of severe and chronic anxiety or depression.
Vocational	Employer warnings re: absenteeism or tardiness related to drug abuse. Decline in productivity. Problems in getting along with fellow employees. Drug abuse during work hours, i.e., during lunch periods, coffee breaks.	Drug abuse on the job. Frequest absences from from work. Disciplinary actions include suspension or dismissal from job. History of job losses, e.g., two or more job losses due to drug abuse. Frequent movement from one job to another voluntarily. (At least one job change a year for five years or more.	Chronically unemployed. Marginal employment. Frequest job loss due to drug abuse, (i.e., loss of three jobs or more in one year. Substantially underemployed.

Services Covered

Covered services are broadly defined as any item or service considered necessary to render a handicapped individual employable. These may include, but are not limited to:

- Evaluation of rehabilitation potential;
- Counseling, guidance, referral and placement services;
- Vocational and other training services;
- Physical and mental restoration services, including corrective surgery or therapeutic treatment for physical or mental conditions, hospitalization, provision of prosthetic devices and visual services, diagnosis and treatment for mental and emotional disorders;
- Maintenance during rehabilitation; and
- Other services or devices related to an individual's employability such as sensory aids, occupational training, licenses, tools and equipment.

Provider Eligibility

Generally, a state rehabilitation agency works in conjunction with treatment programs to provide additional services to the program's clients. For example, VR may offer employment counseling, skill training, and placement services to an individual who has been treated, or is currently being treated, by a program. In some cases, the state agency will place a VR counselor in the program on a full-time or part-time basis. Less frequently, VR will refer individuals with alcohol and drug problems to a treatment program for services and reimburse the program for such services. State VR agencies have shown some reluctance to expend their limited funds for services provided by another federally supported operation. This is especially true when such services are also made available to individuals without cost.

Establishing a working arrangement with VR normally involves the development of a cooperative agreement, which may or may not be formalized in writing, rather than a contractual arrangement such as required for Medicaid. An agreement of this type outlines the basis for a cooperative relationship between the treatment program and VR, indicating the type of services that will be provided by the respective organizations, at what stage in the treatment process referrals will be made, etc. Further details can be obtained from your local vocational rehabilitation agency.

Division of Vocational Rehabilitation Field Offices

EAU CLAIRE OFFICE, P.O. Box 1459, 517 Walker Avenue 54701.....(715)836-4263
Counties Served: Barron, Chippewa, Clark, Dunn, Eau Claire, Pepin, Pierce, Polk, St. Croix

FOND DU LAC OFFICE, P.O. Box 1438, 485 S. Military Rd 54935.....(414)921-5883
Counties Served: Calumet, Fond du Lac, Green Lake, Marquette

GREEN BAY OFFICE, P.O. Box 3627,1181 Western Ave. 54303.....(414)497-3417
Counties Served: Brown, Door, Kewaunee, Marinette, Menominee, Oconto, Shawano

HAYWARD OFFICE, 100 Second Avenue 54843.....(715)634-4941

JANESVILLE OFFICE, 101 S. Main Street 53545.....(608)755-2780
Counties Served: Green, Rock

LACROSSE OFFICE, 333 Buchner Place 54601.....(608)785-9500
Counties Served: Buffalo, Crawford, Jackson, LaCrosse, Monroe, Trempealeau, Vernon

LADYSMITH OFFICE, 104 W. Second Street, North 54848.....(715)532-3351
Counties Served: Price, Rusk, Taylor

MADISON OFFICE, 1 S. Park Street 53715.....(608)266-3655
Counties Served: Columbia, Dane, Dodge, Grant, Iowa, Jefferson, Lafayette, Richland, Sauk

MADISON CENTRAL OFFICE, 122 W. Washington Avenue 53703.....(608)266-8867
Serves: Dane County, City of Madison, Special Services

MILWAUKEE CENTRAL OFFICE, 819 N. 6th Street 53203.....(414)224-4677
County Served: Milwaukee

MILWAUKEE NORTH OFFICE, 6815 W. Capitol Drive 53216.....(414)224-1888 or 527-0250

MILWAUKEE SOUTH OFFICE, 3555 S. 27th Street 53221.....(414)643-1919

OSHKOSH OFFICE, 424 Washington Avenue 54901.....(414)424-2028
Counties Served: Outagamie, Waupaca, Waushara, Winnebago (including Mental Health Institute)

RACINE OFFICE, 5200 Washington Avenue 53406.....(414)636-3388
Counties Served: Kenosha, Racine

RHINELANDER OFFICE, P.O. Box 894, 130 S. Stevens St. 54501.....(715)369-3930
Counties Served: Florence, Forest, Langlade, Lincoln, Oneida Vilas

RICE LAKE OFFICE, 221 N. Main Street 54868.....(715)234-3612

SHEBOYGAN OFFICE, 832 Niagara Avenue 53081.....(414)459-3883
Counties Served: Manitowoc, Sheboygan

FIELD OFFICES (cont'd) TELEPHONE

SUPERIOR OFFICE, 917 Tower Avenue 54880.....(715)392-8171
Counties Served: Ashland, Bayfield, Burnett, Douglas, Iron, Sawyer, Washburn

WAUKESHA OFFICE, 1570 E. Moreland Boulevard 53186.....(414)547-0171
Counties Served: Ozaukee, Walworth, Washington, Waukesha

WAUSAU OFFICE, 111 W. Wausau Avenue 54401.....(715)845-9261
County Served: Marathon

WISCONSIN RAPIDS OFFICE, 110 E. Grand Avenue 54494.....(715)424-1100
Counties Served: Adams, Juneau, Portage, Wood

WORKSHOP FOR THE BLIND, 5316 W. State Street, Milwaukee 53203.....(414)771-5311

U.S.D.A. - FOOD NUTRITIONAL SERVICES FOOD STAMP PROGRAM

The Food Stamp Act of 1964 established a program to distribute, through normal channels, food subsidized by federal and state governments. The aim of the program is to provide for improved nutrition in low-income households. Eligible households (a family or economic unit, including individuals living alone) can receive coupons through the welfare agency. Recipients pay a percentage of the coupons' face value and may then use them to buy food products at retail stores authorized to participate in the program. The sole criterion for eligibility is income level, provided that all able-bodied adults in the household, except students and those caring for dependent children or disabled adults, are employed or actively seeking employment.

Relevance to Drug Abuse Programs

Amendments to the Act make drug addicts and alcoholics participating in a treatment program who qualify on the basis of income eligible for stamps.

There are three ways in which they may obtain benefits:

- A client in an outpatient treatment program, living alone or as a member of a household, may obtain and use food stamps for his household meals. Food stamps are obtained by the individual or household through normal welfare agency procedures.

- A client in a day-care treatment program, living alone or as a member of a household, may obtain food stamps and use them to pay for meals at the program (if the program normally charges its clients for such meals and is authorized to redeem the coupons) as well as for his own meals at home. Food stamps are obtained by the individual or household through normal welfare agency procedures.

- A client living in a residential treatment program may obtain food stamps jointly with the program, for the program to use in providing his meals. In this case, food stamps are obtained through a special procedure.

The third category may be considered a form of third party payment since the program is reimbursed for a portion of the cost of providing meals to the client. To receive food stamps, the county welfare agency must certify that both the client and the program are eligible. Clients must meet the standard eligibility criteria. Eligibility criteria for the program are: 1) it must have written approval as a treatment program by DHSS; 2) it must be a private, nonprofit organization (separate treatment programs, or "units," within the same organization must apply separately); and 3) it cannot receive federally donated foods in duplication of the Food Stamp Program benefits.

For certification to receive food stamps, the program and its clients must apply to the county welfare agency. Each client applicant must be individually approved as eligible. For authorization to accept and redeem food stamps, the program must apply to its Food and Nutrition Field Office. (see below) Approval of all these applications will mean: 1) the client, in conjunction with the program, is certified to receive food stamps; and 2) the program is authorized to accept the stamps as payment for the meals it provides the client and redeem them at face value (as if it were a retail food store), through similarly authorized wholesalers (for goods or cash) and banks (for cash and credit).

FOOD NUTRITION SERVICES OFFICES AND COUNTIES SERVED

U.S. Department of Agriculture
Food and Nutrition Service
Thomas M. Graski, Officer-in-Charge
USDA Building - Room 12
518 Potomac Lane
Madison, WI 53711 Telephone: 608: 831-7033

Adams, Columbia, Crawford, Dane, Dodge, Grant, Green, Green Lake, Iowa, Jackson, Jefferson, Juneau, Kenosha, LaCrosse, Lafayette, Marquette, Milwaukee, Monroe, Ozaukee, Racine, Richland, Rock, Sauk, Vernon, Walworth, Washington, Waukesha, Waushara.

U.S. Department of Agriculture
Food and Nutrition Service
Donald F. Hoffmann, Officer-in-Charge
Capitol Building
1540 Capitol Drive
Green Bay, WI 54303 Telephone: 414: 465-3806

Ashland, Brown, Calumet, Clark, Door, Florence, Fond du Lac, Forest, Iron, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Menominee, Oconto, Oneida, Outagamie, Portage, Price, Shawano, Sheboygan, Taylor, Vilas, Waupaca, Winnebago, Wood

U.S. Department of Agriculture
Food and Nutrition Service
Karl P. Kenyon, Officer-in-Charge
Federal Building - Room B-35
515 W. First Street
Duluth, MN 55802 Telephone: 218: 727-6692 ext. 334

Barron, Bayfield, Burnett, Douglas, Polk, Rusk, Sawyer, Washburn

U.S. Department of Agriculture
Food and Nutrition Service
Donald R. Hohage, Officer-in-Charge
Federal Building and U.S. Courthouse, Room 164
316 Robert Street
St. Paul, MN 55101 Telephone: 612: 725-7805

Buffalo, Chippewa, Dunn, Eau Claire, Pepin, Pierce, St. Croix, Trempealeau.

FORM APPROVED OMB NO. 40-R3187

FORM FNS-252-2 (5-74) U.S. DEPARTMENT OF AGRICULTURE FOOD AND NUTRITION SERVICE

MEAL SERVICE

APPLICATION FOR AUTHORIZATION TO PARTICIPATE IN THE FOOD STAMP PROGRAM FOR COMMUNAL DINING FACILITIES, DRUG ADDICTION OR ALCOHOLIC TREATMENT AND REHABILITATION PROGRAMS, AND NONPROFIT MEAL DELIVERY SERVICES

FNS(FS) Instr. 745-9

FOR USDA USE ONLY

AUTHORIZATION NO.	DATE AUTHORIZED

PROJECT AREA

INSTRUCTIONS: Items 1 through 14, 20 and 21 must be completed by ALL applicants. For the sponsored program indicated in item 1 applicants must complete the following item(s), as indicated:

	Communal Dining Facility	Drug Addiction Treatment & Rehabilitation Program	Alcoholic Treatment and Rehabilitation Program	Nonprofit Meal Delivery Service
Items	15, 16, 17	15, 18	15, 19	16

1. TYPE OF PROGRAM SPONSORED *("X" applicable box)*

☐ COMMUNAL DINING FACILITY ☐ DRUG ADDICTION TREATMENT AND REHABILITATION

☐ ALCOHOLIC TREATMENT AND REHABILITATION ☐ NONPROFIT MEAL DELIVERY SERVICE

2. NAME OF MEAL SERVICE

3. NAME AND MAILING ADDRESS OF KITCHEN FROM WHICH MEALS ARE SERVED *(Include ZIP)*

4. COUNTY OR CITY

5. NAME AND MAILING ADDRESS OF SPONSORING AGENCY *(Include ZIP)*

6. NAME, TITLE, AND ADDRESS OF PERSON RESPONSIBLE FOR OPERATION OF MEAL SERVICE

7. TELEPHONE NO.

8. DAYS MEALS ARE SERVED *("X" those applicable)*

☐ MON. ☐ TUE. ☐ WED. ☐ THUR. ☐ FRI. ☐ SAT. ☐ SUN.

9. MEALS SERVED *("X" those applicable)*

☐ BREAKFAST ☐ LUNCH ☐ DINNER

10. HAS PERSON NAMED IN ITEM 6 ABOVE OR PERSON SIGNING THIS APPLICATION PREVIOUSLY OWNED OR OPERATED ANOTHER FIRM FOR WHICH APPLICATION TO PARTICIPATE IN THE FOOD STAMP PROGRAM WAS SUBMITTED? ☐ YES ☐ NO *(If YES, give name and address of firm and when application was submitted)*

11. IS SPONSOR CURRENTLY EXEMPT FROM FEDERAL INCOME TAX UNDER INTERNAL REVENUE SERVICE CODE? ☐ YES ☐ NO

12. MONTHLY CHARGE PER CUSTOMER? ☐ YES ☐ NO

If YES, amount of monthly charge $.....

13. DOES MEAL SERVICE, KITCHEN, OR SPONSOR CURRENTLY PARTICIPATE IN THE FOOD DISTRIBUTION PROGRAM? ☐ YES ☐ NO

If YES, which agencies participate? ☐ MEAL SERVICE ☐ KITCHEN ☐ SPONSOR

14. AVERAGE MONTHLY SALES OF MEAL SERVICE

$.....

15. NAME AND MAILING ADDRESS OF SITE WHERE MEALS ARE SERVED *(Include ZIP)*

16. IS SPONSOR PRESENTLY RECEIVING FUNDS UNDER TITLE VII OF THE "OLDER AMERICANS ACT"? ☐ YES ☐ NO

17. IS MEAL SERVICE A PRIVATE ESTABLISHMENT UNDER CONTRACT WITH A STATE OR LOCAL AGENCY TO PROVIDE MEALS PREPARED ESPECIALLY FOR ELDERLY PERSONS AND SOLD AT CONCESSIONAL PRICES DURING REGULAR OR SPECIAL HOURS? ☐ YES ☐ NO

18. IS SPONSOR PRESENTLY CERTIFIED BY THE STATE AS PROVIDING TREATMENT THAT CAN LEAD TO THE REHABILITATION OF DRUG ADDICTS AS SPECIFIED IN THE "DRUG ABUSE OFFICE AND TREATMENT ACT OF 1972"? ☐ YES ☐ NO

19. IS SPONSOR PRESENTLY CERTIFIED BY THE STATE AS PROVIDING TREATMENT THAT CAN LEAD TO THE REHABILITATION OF ALCOHOLICS AS SPECIFIED IN THE "COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970"? ☐ YES ☐ NO

20. REMARKS AND/OR ADDITIONAL INFORMATION *(If more space is needed, continue on reverse)*

21. STATEMENT: The meal service designated in item 2 above hereby applies for authorization to participate in the FOOD STAMP PROGRAM (the Program). The meal service has received and understands Part 270, "General Information and Definitions," and Part 272, "Participation of Retail Food Stores, Wholesale Food Concerns, Meal Services, and Banks," 7 C.F.R. Parts 270 and 272 of the Federal regulations governing the Program (the Program regulations). The meal service represents that it and its employees will comply with the Program regulations and understands that any authorization to participate in the Program granted to it may be withdrawn for any violations of the Program regulations by it or any of its employees. The meal service, to the best of its knowledge and belief, qualifies as a "meal service" as defined in the Program regulations. The meal service intends to serve (or, where applicable, deliver) meals for those food stamp recipients who are eligible to use the coupons for such meals.

The meal service asserts that all of the statements in this application are true and correct and understands that false information contained herein may result in the denial or withdrawal of approval to participate in the Program. The meal service further understands that approval to participate will be automatically withdrawn and asserts that it will immediately cease acceptance of food coupons upon loss of its Federal tax exempt status, or cancellation or expiration of its contract with the State or local agency, or loss of its State certification, as appropriate. The undersigned represents that he is a member of the sponsoring agency and that he has authority to contract for and in behalf of the meal service, OR: The undersigned represents that he is either the sole proprietor of the private establishment or that he has authority to contract for and in behalf of the private establishment.

DATE	TITLE	SIGNATURE

Previous edition obsolete. APPLICATION WILL NOT BE PROCESSED UNLESS ALL APPLICABLE ITEMS ARE COMPLETED

Directions for Completing Forms FNS-252-2 Submitted by Communal Dining Facilities for the Elderly.

Item 1 Self Explanatory

Item 2 Self Explanatory

Item 3 Self Explanatory

Item 4 Enter the name of the county or independent city in which the kitchen is located.

Item 5 Enter the name and address of the agency which accepts full responsibility for the operation of the firm.

Item 6 Enter the name and title of the person who is responsible for the daily operations of the meal service. Enter the address at which this person may be located during the day.

Item 7 Enter the telephone number at which the person listed in Item 6 may be reached during the day.

Item 8 Self Explanatory

Item 9 Self Explanatory

Item 10 Self Explanatory

Item 11 Self Explanatory

Item 12 Enter the cost to a customer for a month of meals. If the cost is determined according to income, enter the average cost or the range in which the charge falls. If payment for meals is made on a donation basis, this should be so indicated. The figure indicated may be a combined total, i.e., breakfast, lunch and dinner, or it may be given separately for a monthly service of each meal.

Item 13 Self Explanatory

Item 14 Average the monthly total sales for the past year. If the meal service has not been operating for a year, average the sales for the time it has been in operation. If the firm is new, estimate the monthly sales. Indicate that the figure is an estimate. (If payment for meals is on a contribution basis, enter the total estimated monthly contribution.) This information will be strictly confidential.

Item 15 If the site where meals are served is located in a particular institution, give the name of the institution. Enter the address of the site.

Indicate the county or independent city the site is located in if it is different than the county or city indicated in Item 4.

Item 16 Self Explanatory

Item 17 Self Explanatory

Item 18 Not applicable to the communal dining facilities covered by these instructions.

Item 19 Not applicable to the communal dining facilities covered by these instructions.

Item 20 Self Explanatory

Item 21 Please note the statement that the applicant firm agrees that it and its employees will abide by the regulations. ("Employees" include both paid and volunteer personnel.)

HEALTH INSURANCE PRIVATE THIRD PARTY PAYERS

Health policies are offered by virtually every type of insurance company--life insurance, casualty, accident and sickness underwiters, and, of course, those formed specifically for the purposes of providing health coverage. Various types of coverage are also offered by unions, by companies formed to provide coverage for specific occupations, and by fraternal organizations.

Insurance companies are generally divided into two types: mutual companies (organized to provide coverage for members at cost), and stock companies (designed to make a profit).

Insurance policies may be issued by either type of company to both groups and invididuals. Group policies are written to cover the employees of a firm or the members of an association. One policy is issued for all employees or members wishing coverage. Individual policies, on the other hand, are issued to one person or a family unit.

Services Covered

Both individual and group policies can offer an enormous range of services. Some may cover only hospitalization, while others may cover doctor's fees, outpatient treatment, psychiatric care, pharmacy charges, or disaster coverage against major disease or surgery. Specific coverage will vary with respect to the particular company writing the policy as well as with respect to the particular type of policy purchased. This is especially true of group policies, as the organization purchasing the policy has considerable latitude in specifying both the type of services to be covered and the extent to which they will be covered (e.g., full coverage or a dollar limit). Group policies, therefore, tend to be customized for the buyer. Thus, two individuals having group medical coverage written by the same insurance company but who are employed by different firms may have very different coverage. As an example, the Michigan Blue Cross/Blue Shield contract with the United Auto Workers specifically covers the treatment of substance abuse, however, other policies written for other customers by this carrier do not include such coverage.

Variability in services covered relates to types of illnesses and to the specific conditions under which services are provided. Thus, even if alcoholism and drug abuse are included in the list of covered illnesses, a policy may impose specific conditions. Examples of such conditions are: (a) Services must be provided by a licensed physician, (b) Services must be provided under the direction of a licensed physician, (c) Services must be provided to inpatients in an accredited facility. Additional restrictions may further limit services by such factors as length of time, number of encounters, and/or eligibility of dependents (e.g., "up to 18 unless a student").

Although the particular coverage provided and the specific terms and conditions affecting each coverage (e.g., dollar or durational limits) will vary from policy to policy, there are certain basic categories of coverage that are offered by most companies writing health insurance. These are:

Hospitalization. This type of insurance (also referred to as "basic protection") covers care in a hospital for periods ranging from 30 to 365 days or longer, depending on the particular policy.

In general, these benefits help pay for two types of services:

1. Daily room and board in the hospital, routine nursing care and minor medical supplies.

2. Other hospital services, such as laboratory tests and X-rays, anesthesia and its administration, use of operating room, drugs and medications, and local ambulance service. These services may be referred to as miscellaneous or ancillary expenses.

Frequently the benefit of these additional services is expressed as being so many times the room and board benefit. For example, if the room and board benefit is $50 a day, the additional expense benefit may be 10 times this amount, or $500.

Additional terms and conditions generally used by private insurers that serve to limit reimbursement are:

Coinsurance, in which the insurance company and the insured each pay a percentage of the cost of treatment. For example, under the terms of the policy, the insured service-recipient may pay 20 percent and the insurance company 80 percent of the costs incurred.

Deductible, which specified an amount of covered expenses that must be incurred by the insured before benefits become payable by the insurer. For example, the insured may have to pay the first $100.

Mandatory Coverage for Drug Abuse and Alcoholism

In an attempt to ensure medical coverage for alcoholism and drug abuse on the part of private carriers, the legislature created s. 632.89 Wis. Stats. that applies to health insurance policies written by firms licensed to write insurance in the state. (See copy of the law in following pages.)

Major Medical. This type of coverage provides protection against the costs of serious and prolonged illnesses. The maximum amount such a policy pays varies. Some pay up to $20,000; some up to $250,000; some have no limit at all. A high-benefit policy is popularly known as "catastrophic coverage." Major medical benefits cover virtually every type of care and treatment prescribed by a physician, both in and out the the hospital, for example:

- Hospital services;
- Physician's treatment and specialist's consultation and care;
- Prescribed drugs and medicines.

Major medical insurance has a deductible amount that is paid by the insured or by the "Basic Protection" insurance before Major medical benefits start. This can range from $50 to $1,000 or more, depending on the policy.

Hospital Indemnity. These cash benefit policies provide money to help meet additional expenses during an illness. Usually these benefits are paid only for the time during which the insured is hospitalized.

Client Eligibility

Coverage is dependent on the payment of premiums, either by the individual policyholder or the group policyholder.

Client eligibility is automatic in the case of a group policy (i.e., all members of the group must be covered by the underwriter). However, in the case of an individual, eligibility might be related to factors such as age, physical condition, or family medical history.

An important consideration in regard to private insurance coverage for alcoholism/drug abuse will be an individual's employment status. Since an alcoholic or drug addict is most likely to use his income to support his habit and provide for the basic necessities, he is not likely to have medical insurance unless it is provided by his employer. Therefore, determination of the proportion of your client population that is employed is basic to assessing the likelihood of obtaining reimbursement from private carriers.

Provider Eligibility

Specific provider eligibility criteria may vary from carrier to carrier. However, an individual provider generally must be a "licensed practitioner" and an institutional provider or outpatient program must be state licensed and/or approved.

Obtaining Provider Status

In order to be approved as a provider by a private carrier, you will generally have to submit a formal application, together with any supporting material specified by that carrier. Note: Such approval must be obtained from each carrier and the specific requirements and procedures will vary with each carrier. Most typically, the information required relates to:

- Identification of the facility (name, address, phone, etc.),
- Type of credentialing already obtained,
- Size and professional qualifications of staff,
- Fee schedule, and
- Client population

Additionally, some carriers will require an on-site inspection by their representative.

A WORD ABOUT HEALTH MAINTENANCE ORGANIZATIONS

Legislative Overview

Federally funded HMO's are required to provide or arrange for the provision of basic health services to their members as needed, and without limitations as to time and cost. These requirements were an integral service component of the HMO Act of 1973, and the subsequent HMO Amendments of 1976 (P.L. 94-460). Specific requirements impinging on alcoholism treatment include:

- Provision of basic health services, medical treatment, and referral services for the abuse of or addiction to alcohol and drugs
- Provision of medically necessary emergency health services
- Provision of short-term outpatient evaluative or crisis intervention mental health services

In addition, the 1976 HMO Amendments include the following provisions:

- Each supplemental benefit need not be offered; therefore, only those supplemental benefits for which there is a demand will be offered. Because of this option, a plan does not have to supply alcoholism benefits to all enrollees, beyond the basic requirements.
- A minimum benefit package which exceeds basic requirements by inclusion of one or more specified supplemental benefits is allowable.

The 1976 Amendments do not enunciate the specific types and amounts of alcoholism services to be provided. However, federal regulations promulgated with respect to the 1973 Act indicated that:

- Medical treatment means detoxification for alcohol and drug abuse on either an outpatient or inpatient basis, in addition to treatment for other medical conditions.
- Referral services may be for either medical or nonmedical ancillary services.
- Medical services are part of basic health services; nonmedical ancillary services need not be a part of basic health services.

While regulations are yet to be promulgated with respect to the 1976 Amendments, it is likely that the same types of regulatory definitions will remain.

BLUE CROSS/BLUE SHIELD

Blue Cross and Blue Shield are a loosely knit group of private, nonprofit insurance companies (formally referred to as "plans"). Each plan is a separately administered, local corporation authorized to use the Blue Cross or Blue Shield name and emblem. Although Blue Cross and Blue Shield are separate programs, each having its own national association, in most areas they cooperate closely with one another.

Blue Cross provides coverage for hospital expenses that include hospital room plus other related services such as laboratory, X-ray, medication, and operating room. Blue Shield covers such physician's services as office visits, surgical fees, etc.

The various Blue Cross/Blue Shield plans operate much the same as private insurance companies. They have the same degree of inter-organizational variability with respect to services covered and criteria that determine client and provider eligibility. However, with respect to provider eligibility, nearly all require state licensure and/or accreditation by a recognized organization such as JCAH or AOA. Many also require a certificate of need from the local department of public health specifying that the provider is necessary in the community and not duplicating services offered by others.

In most cases, initiation of an agreement with a Blue Cross/Blue Shield plan will involve a formal contract, the terms of which will vary according to the plan and nature of services to be furnished.

State of Wisconsin, Insurance Law Relating to Treatment of Alcoholism and Drug Abuse

632.89 Required coverage of alcoholism and other diseases. (1) DEFINITIONS. In this section:

(a) "Outpatient treatment facility" means a facility licensed or approved by the department of health and social services whose outpatient services meet the standards established in s. 51.42 (12) and which provides those services, except inpatient services, enumerated in s. 51.42 (5) (b) to (d) for the prevention and amelioration of mental disabilities, including but not limited to mental and nervous disorders, alcoholism and drug abuse.

(b) "Hospital" is a facility described in s. 140.24(1)(a) and (c) which is licensed under s. 140.26 or is an approved public or private treatment facility for the treatment of alcoholics as defined in s. 51.45 (2)(b) and (c).

(c) "Physician" has the meaning designated in s. 990.01(28).

(d) "Outpatient services" means services, medications, equipment and supplies performed or furnished by or under the supervision of or on referral from a physician at a hospital or outpatient treatment facility to a patient who is not a bed patient of the hospital or outpatient treatment facility.

(2) REQUIRED COVERAGE FOR ALL INSURERS UNDER CHAPTERS 611 AND 613. (a) Scope. Each group disability policy, joint contract or contract providing hospital treatment coverage shall include coverage for:

1. Inpatient hospital treatment of mental and nervous disorders, alcoholism and drug abuse.

(b) Exclusions in coverage. Except as provided in par.(c), coverages under pars. (a) and (d) may not be subject to exclusions or limitations which are not generally applicable to other conditions covered under the policy or contract.

(c) Minimum confinement. Coverages under par. (a) 1 may not provide less than 30 days' confinement in any calendar year.

(d) Outpatient treatment. Every contract or joint contract issued by an insurer subject to this section providing coverage for outpatient treatment shall provide coverage for outpatient services for mental and nervous disorders, alcoholism and drug abuse including but not limited to partial hospitalization services, prescribed drugs and collateral interviews with patients' families, relating to diagnosed alcoholism, drug abuse, or mental and nervous disorders of the patient, in an amount not less than the first $500 in any calendar year for any alcoholism or drug abuse services, or for outpatient services provided by or under contract for a board established under s. 51.42, and $500 for any other outpatient services for mental and nervous disorders. No contract or joint contract written in combination with major medical coverage shall be required to provide coverage under this paragraph for more than $500 for any combination of disabilities required to be covered under this paragraph. The department of health and social services may by rule promulgated under ch. 227 adjust this amount at 2-year intervals to reflect changes in the cost of medical care.

(3) ADDITIONAL REQUIRED COVERAGE FOR CORPORATIONS SUBJECT TO CH. 613. Any corporation subject to ch. 613 is subject to sub. (2) and in addition its group disability policies, joint contracts or contracts which provide for hospital contracts or contracts which provide for hospital treatment or outpatient treatment shall provide:

(a) Outpatient hospital treatment of alcoholism;

(b) Outpatient and home dialysis treatment for kidney disease and kidney transplantation expenses; and

(c) Protection for both recipient and donor of any transplant organs, as provided in s. 49.48(3)(b).

(4) AMOUNT OF PROTECTION FOR ORGANIZATIONS SUBJECT TO SUB. (3). Coverage under sub. (3)(b) and (c), combined with coverage under s. 632.78 (2), shall not be less than $30,000 annually.

(5) MEDICARE EXCLUSION. No insurer or other organization subject to this section is required to duplicate coverage available under the federal medicare program.

(6) RULES. The department of health and social services may by rule impose reasonable standards for the treatment of kidney diseases required to be covered under this section and s. 632.78(2), which shall not be inconsistent with or less stringent than applicable federal standards.

Compliance with existing law varies with insurers. Programs should bill for services in every case where coverage is indicated.

In the event a claim is denied, the insured should refer the matter to the office of the Commissioner of Insurance. This can be accomplished in the form of a letter which should contain at a minimum:

1. A statement of the issue(s).
2. The name of the insurance company and group number.
3. The letter (or copy) of the letter of declination from the insurer.

The commissioner will review the claim on the basis of the issues as they relate to the policy and request a statement from the insurer following which he will either confirm the denial or direct the insurer to honor the claim. Non-compliance by the insurer could result in loss of license to operate in the State.

Commissioner of Insurance
123 W. Washington Avenue
Madison, WI 53702

For assistance call: Clifford Bertagnoli, Director, Third Party Payment, BAODA.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

CHAMPUS is a comprehensive hospital and medical health benefit program for dependents of active duty, deceased and retired personnel, plus retired members of the military entitled to retirement retainer or equivalent pay. Generally, any treatment furnished on an inpatient or outpatient basis and considered acceptable medical practice will be authorized as a CHAMPUS benefit, except for services excluded by law. The program only reimburses for services; it does not offer prepaid programs.

Provider Eligibility

Credentialing is of utmost importance to CHAMPUS. A facility may be credentialed through approval by the Joint Commission on Accreditation of Hospitals, certification for Medicaid and/or Medicare, or it may be licensed by the appropriate state.

Generally, facilities with any such accreditation receive provider status upon submission of a formal application. Any drug center seeking reimbursable status requires approval from the national office in Denver as well as from the fiscal administrator. The "fiscal administrator" is an intermediary organization (frequently Blue Cross) that processes claims.

Once a facility has acquired provider status, CHAMPUS does little monitoring. Presumably, any appropriately licensed facility must maintain standards and is monitored by the licensing agency.

CHAMPUS requires no regular reporting schedule. The only way CHAMPUS maintains quality control is through random visits by the fiscal administrator, if outpatient care is provided, and by the Denver office for those facilities providing inpatient services.

In each state a fiscal administrator manages the CHAMPUS program and inspects provider premises to evaluate the physical facility. This site visit is required for accreditation, along with acceptance of the written application by the Denver office.

The fiscal administrator also approves all outpatient care and receives all money directly from the government for this care.

Submit claims to:

Wisconsin Physicians Service
P. O. Box 1787
Madison, WI 53701

DEFINITIONS - ADDITIONAL TERMS

ACCOUNT NUMBER (See also VENDOR NUMBER)

A control or identification number assigned by a Medicare, Medicaid or private insurance fiscal agent to a provider when the provider is certified as eligible for reimbursement on legitimate claims.

AFFILIATION (See also PARENT ORGANIZATION and FREE STANDING)

(a) Grant Affiliation--The fiscal relationship between an organization operating a project, a project and a parent organization which is the legal recipient of grant funds and exercises administrative control over the project.

(b) Services Affiliation--The relationship between an organization operating a project, a project and another health services delivery organization, created by a formal or informal agreement, under which the other organization provides certain health or other services to the project's patient. For example, a project often negotiates with a hospital for the provision of inpatient services to project patients.

AID TO FAMILIES WITH DEPENDENT CHILDREN (Title IV-A)

Program of payment for social services for children and families under Title IV-A of the Social Security Act. Resources may also be available under the adult categories of Titles I, X, XIV and XVI of the Social Security Act.

AMBULATORY CARE

Health services rendered to persons who are not confined overnight in a health care institution. Ambulatory care services are often referred to as "outpatient" services.

ASSIGNMENT OF BENEFITS

A procedure authorized by many third-party payors by which the patient assigns his right to reimbursement to the provider. The provider then collects directly from the third-party, or the patient's account. From the patient's perspective, assignment is similar to endorsing a check for payment to another.

BENEFIT STRUCTURE

A precise description of the services for which a third-party payor will provide reimbursement when the services are rendered to patients eligible for coverage under the payor's plan. Usually this description is in the form of a list of specific reimbursable services; occasionally, it may be in the form of the statement that all services of a general type (e.g., physicians' services" are covered except certain specified exclusions.

BILLING EFFICIENCY

A measure of the accuracy, speed, and cost with which bills or claims are prepared for submission to patients or third-party payors.

BUDGET

A project's plan for expenditure of funds to support designated health care services and essential related services for a specified period of time.

BUDGET PERIOD

The interval of time, usually 12 months, into which the project/program period is divided for budgetary purposes. Each application, financial plan, award notice, and report of expenditures is prepared on a budget period basis.

BUREAU OF HEALTH INSURANCE (BHI)

A bureau of the Social Security Administration which administers the Medicare health insurance program.

BUY-IN

An option granted to states to enable them to use federal Medicaid funds to buy Medicare Part B coverage (outpatient) for Medicaid recipients eligible for Medicare coverage as well. This buy-in reduces Medicaid responsibility to the deductible and coinsurance amounts for services under Medicare.

CAPITATION

(a) The common term applied to the arrangement in which a patient enrolls in a health care institution and agrees to pay a periodic fixed charge for a specified set of services, regardless of whether or not he uses such services.

(b) The fixed charge, assessed per capita or per family unit, for enrollment in a membership plan which provides health care services on a prepaid basis.

CARRIER

An organization (usually a corporation, insurance agency or voluntary association) which reimburses the cost of health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or other group arrangements. In the Medicare program, carriers reimburse for services covered under Title XVIII, Part B, except in cases in which providers are reimbursed directly by BHI. In the Medicaid program, the single state agency (see definition below) administering the program in any state may appoint a carrier to act as fiscal agent for Medicaid reimbursements or may elect to perform this function itself.

CASH FLOW

The stream of cash receipts and disbursements generated in the course of program operations. The combined effect of these streams is the net cash position of the institution.

CATCHMENT AREA

The geographic area from which a particular program or facility draws the bulk of its users. Catchment areas are frequently prescribed by program guidelines and described in a project's grant application.

CATEGORICALLY NEEDY

The descriptive designation of one of two classes of Medicaid eligible persons (Compare Medically Needy). The categorically needy receive Medicaid benefits because they are eligible for welfare benefits defined categorically for the blind, the disabled, the aged, and families of dependent children. All states participating in Medicaid must cover required services for the categorically needy.

CENTER

A medical service treatment facility.

CHAMPUS

The Civilian Health and Medical Program for the Uniformed Services, a program providing medical services to military dependents and retired military personnel administered by the Office for CHAMPUS, Denver, Colorado.

COINSURANCE

A percentage of the total service cost that the patient must pay. Coinsurance under Medicare, Part B, is a uniform 20 percent; some states mandate coinsurance under Medicaid as well. Coinsurance is computed after the deductible has been satisfied. For example,[1] when a Medicare patient incurs a $100 bill, he is responsible for $60 (deductible), then for 20 percent of remaining $40), or $8.00; Medicare should pay $32.

COSTS

Definitions of such items as direct costs, indirect costs, and total cost are found in HSMHA Grants Policy Statements.

COVERED SERVICES

The services delivered by a project which are included in the benefit structures of one or more third-party payors. Compare "Benefit Structure." Note that a project will have various packages of covered services, because services are covered variably by different third-party payors. These packages are defined by matching individual service units with benefit structures covering project patients, such as Medicare, Medicaid, and private insurance plans.

1/ This example is simplified for present purposes. Actually, the patient is only responsible for the annual deductible, not a deductible on each bill.

DEDUCTIBLE

A specified dollar amount which a patient is expected to pay personally toward the cost of his health care services during a designated time period before he is eligible to receive reimbursement under a third-party reimbursement program. Under the Medicare program, for example, each patient is expected to pay the first $60 of the cost of Medicare-covered services each year. Records indicating application of deductible provisions to individual patient accounts are maintained by carriers.

DIRECT PATIENT PAYMENTS

Any form of direct patient payment (including deductibles or coinsurance) to the project for services rendered. Direct patient payments may be either for the full cost of services rendered or for some predetermined portion of those costs. See also: coinsurance, deductible, sliding scale.

DISBURSEMENTS

Payments made for the receipt, consumption, or use of goods or services, or in the liquidation of a financial obligation.

ELIGIBLE PATIENTS

Patients qualifying for benefits under third-party reimbursement plans such as Medicare, Medicaid, or private insurance plans.

ENCOUNTER (See also SERVICE UNIT)

A face-to-face contact between a user and a health care provider. (See definitions of both terms below.) An encounter does not encompass such services as a laboratory technician drawing blood or collecting urine specimens nor does it include an X-ray technician taking an X-ray film. Each encounter involves a provider who must be acting independently and not assisting or executing orders of another provider. The number of encounters for any one user in any one day is the number of individual providers with whom the user has had face-to-face contact, including contacts resulting from provider referrals for consultation or other purposes.

ENROLLEE POPULATION

Persons who enter into a contractual relationship to receive specific health care benefits and/or services for a specified period of time from a specified provider source. (Compare "Capitation.")

EPSDT

Early Periodic Screening, Diagnosis, and Treatment (of conditions found)--a program required to be included and covered in state Medicaid plans, in which screening, diagnostic, and treatment services are provided to all Medicaid-eligible persons under the age of 21.

FEDERAL EMPLOYEES' HEALTH BENEFIT PROGRAM

A government-sponsored, voluntary, group health insurance program for federal

employees, annuitants, and their dependents. The program is offered through a number of private insurance companies and group health plans, each of which develops its own benefit structures and premium.

FEE-FOR-SERVICE

A procedure for charging patients or third-party payors in which different fees are charged for different services, according to a schedule of fees set by the provider. (Compare "Capitation" and "Statistical Visit Charge.")

FEE SCHEDULE

(a) A provider's fee-for-service schedule; or

(b) A payor's listing of acceptable fees, established allowances, or maximum payments for specified medical procedures.

FINANCIAL INVENTORY

The questionnaire developed by HSMHA to assess a project's potential for collecting third-party reimbursements.

FINANCIAL PLAN

A set of forms developed by HSMHA for presenting a project's financial management goals with respect to the operation of the project.

FISCAL AGENT

The appropriately designated company or agency responsible for reimbursing providers (see definition) for covered services to eligible persons. The responsibility of a given fiscal agent is typically limited geographically to a particular county, state, or region.

FREE-STANDING PROJECT (or FREE-STANDING CENTER)

A project physically, administratively, and fiscally independent of any other organization; a direct recipient of grant funds. See "Affiliated" and "Parent Organization."

HEALTH CARE PROVIDER

See Provider.

INCOME

Funds or monies flowing into a project for support of its operations. For example:

- Project grants from governmental or non-governmental sources
- Payments received on a fee-for service basis (see definition) regardless of whether received from patients or from third-party payors.

. Donations or philanthropic contributions

INDEMNITY PLAN

An insurance plan which pays its beneficiaries for specific, named losses incurred. Medical insurance plans which pay specified amounts for designated health care services only are an example of this type.

IN-KIND CONTRIBUTION

The value of resources other than cash contributed by (1) the provider organization, (2) other public agencies and institutions, and (3) private organizations and inviduals. Such resources can include the value of real property and equipment, and of goods and services directly benefitting and specifically identifiable to the grant program.

INTERMEDIARY (Compare CARRIER)

The fiscal agent authorized by Medicare to administer reimbursement for Medicare Part A. (Part A deals with institutional providers (see definition) such as hospitals, extended care facilities, home health agencies, independent laboratories, etc.) In certain types of transactions an intermediary may perform also the functions of a carrier in disbursing Part B reimbursements.

MEDICAID

Title XIX of the Social Security Act Amendments of 1965--A federal-state program under which the categorically and medically needy are assisted in paying their costs of health care. The federal legislation authorizes federal grants to states to cover varying shares of the costs of designated medical services provided. All states except Arizona presently participate.

MEDICARE

Title XVIII of the Social Security Act Amendments of 1965--A hospital insurance program for the aged and supplementary medical insurance benefits for ambulatory care. As a general rule, Medicare Part A deals with inpatient care, Part B (Supplementary Medical Insurance) with outpatient care. Part A is automatic in that everyone eligible is included. Part B coverage is extended only when the patient enrolls and pays a monthly premium (presently $5.80 a month, to be increased to $6.30 on July 1, 1973).

MEDICAL SERVICES ADMINISTRATION (MSA)

The federal agency responsible for administering the Medicaid program, in the Social and Rehabilitation Service, DHEW.

MEDICALLY NEEDY (or MEDICALLY INDIGENT)

The term describing one of the two classes of Medicaid eligibles who are deemed able to pay routine living costs but unable to pay for medical products or services. Some, but far from all, states cover the medically needy, for such coverage is not required for participation in Medicaid. (Contrast "Categorically Needy.")

PARENT ORGANIZATION

An organization other than a project which receives the project's grant funds and is responsible for administrative control of the project. Parent organizations are typically, but not necessarily, health care organizations.

PREPAYMENT

See CAPITATION, ENROLLEE

PROGRAM TARGET POPULATION

The persons that a program (or project) is mandated to serve by legislation, appropriation, administrative regulation, executive order, etc. Target populations are typically defined by attributes or particular health risk, or residence. (See "Catchment Area.")

PROVIDER

Both a defined "art term" (in Medicare) and a generic term applied to individuals and institutions rendering health services. HSMHA classifications include:

(a) Individual Provider--Physicians, dentists, or other health care personnel who have primary responsibility for assessing the condition of the patient and exercising independent judgment as to the care of the patient, and for services rendered for a given encounter. (See next page.)

(b) Institutional Provider--An institution or organization in which physicians, dentists, or other health care delivery personnel specified in (a) above provide health services. Specific to Medicare, certain of these institutions assume a formal provider status when they are certified to be complying with Medicare Conditions of Participation, for example, for hospitals.

Providers are grouped into three major categories: physicians, dentists, other health care personnel. Programs may classify providers into more detailed categories for their own use. The more detailed categories listed below under the three major categories are illustrative and advisory only. If more detailed categories are used, the rules specified in footnotes 1/ and 2/ are suggested but are not required by this standard. (See below.)

Physicians	Dentists	Other Health Care Personnel
include:	include:	include:
Doctor of Medicine	General Practitioner	Dental Assistant
General Practitioner 1/	Dentist	Dental Hygienist
Intern or Resident	Specialist	Family Health Coord. (include family health worker and community worker)
Specialist 2/	Orthodontist	Genetics Counselor
Allergist	Periodontist	Nurse (include R.N., Nurse Technician, and L.P.N.)
Dermatologist	Oral Surgeon	Nurse Midwife (certified)
Internist	Other Specialty (Specify)	Nurse Practitioner (include Pediatric Nurse Pract.)
Ob-Gynecologist		Nutritionist
Ophthalmologist		Occupational Therapist
Orthopedist		Optometrist
Otolaryngologist		Physical Therapist
Pediatrician		Physician Assistant (or equivalent)
Psychiatrist		Podiatrist
Radiologist		Psychologist
Surgeon		Public Health Nurse
Urologist		Social Worker
Family Practitioner		Speech Therapist
Other Specialty (specify)		Other Health Care Personnel (Specify)
Doctor of Osteopathy		Alcoholism Counselors
		Drug Abuse Counselors

1/ A physician will be classified as a General Practitioner unless board-eligible for a specialty, in which case he will be classified in that specialty.

2/ A physician will be classified as a specialist if he has completed a formal accredited residency training program and is eligible for certification or its equivalence by the specialty board. The list of specialists is illustrative and not complete.

PROVIDER NUMBER

See ACCOUNT NUMBER.

REGISTRANT POPULATION (REGISTRANTS)

Persons who register for service in a particular health care project but who do not enter into a contractual relationship with the project. Such persons are considered registrants even through they have never used a project service. (Contrast USERS.)

RELATIVE VALUE SCALE

A method of determining fees-for-services in which most common services are listed and a unit value assigned to each, based on time required, complexity, and other criteria. In the 1971 Massachusetts Relative Value Scale, for example, a simple injection is rated as eight units, an initial comprehensive history and physical examination of an adult is rated at 70 units, and a cardiac catheterization procedure is rated at 350 units. These units are frequently converted by providers to dollar fees, by multiplying by a constant "conversion factor." In the example above, application of a $1.25 conversion factor would result in fees of $10, $87.50, and $375, respectively, for the three services.

SERVICE UNIT (See also ENCOUNTER)

A unit used to measure the activity or production of a center's department when the term "encounter" is applicable. For example, a medical laboratory's service units are the number of tests performed and a pharmacy's service units are the number of prescriptions filled.

SINGLE STATE AGENCY

The agency designated by a particular state to administer a program such as the Medicaid Program (Title XIX) within that state. Because of the close link between the Medicaid program and the state's welfare program, the single state agency is most often, but not always, the state welfare or social services department.

SLIDING FEE SCHEDULE

A fee schedule under which the fee charged the patient for services varies with the patient's ability to pay, however this ability is determined.

SMI

Supplementary Medical Insurance. See Medicare Part B.

STATISTICAL VISIT CHARGE

A flat rate charged for each patient encounter without regard to the services rendered. This charge is usually determined statistically, utilizing the particular center's average cost per covered encounter or some other statistical averaging mechanism. For example, a patient would be charged the same for a physical examination as for an injection. (Contrasts "Capitation," "Fee-for-Service," and "Relative Value Scale.")

TARGET POPULATION

See PROGRAM TARGET POPULATION.

THIRD-PARTY PAYOR

An organization or agency retained by or acting for the patient for the payment of charges incurred, in this context, medical charges. Examples include Medicare, Medicaid, and private insurance plans such as Blue Shield.

THIRD-PARTY REIMBURSEMENT

Total fees paid by a third party, i.e., some payor other than the user, to a health care provider for health care services received by a user.

TITLE XVIII

See MEDICARE.

TITLE XIX

See MEDICAID.

TITLE IV-A

See AID TO FAMILIES WITH DEPENDENT CHILDREN

USER POPULATION (USERS)

Persons who have had one encounter or more during a specified time period.

VENDOR NUMBER (See also ACCOUNT and PROVIDER NUMBER)

(a) As used by third-party payors--A control or identification number assigned by the appropriate Medicare, Medicaid, or private insurance agency as certification of provider status and authorization for the provider to collect reimbursements for covered services provided.

(b) As used in the federal grants process--A number assigned to a grantee institution or organization for control and identification, accounting and payment purposes.

CHAPTER 4

CONFIDENTIALITY OF PATIENT RECORDS

CONFIDENTIALITY

PROGRAM'S OBLIGATION TO PRESERVE THE CONFIDENTIALITY OF CLIENT INFORMATION

Alcohol and drug abuse treatment programs have both a professional and legal obligation to preserve the confidentiality of client information.

Professional Obligation

As a professional organization collecting information of a personally sensitive nature, programs must ensure that such information is treated in a confidential manner to protect their clients' right to privacy. The release of information regarding a history of drug abuse may be injurious to a client's rehabilitation, employability, and/or social well being. It is the responsibility of the program to make certain that the client is not harmed because of participation in treatment. Further, since a drug treatment program operates as a provider of medical services, client information becomes a medical record and must be treated accordingly.

Legal Obligation

The federal government recognizes the client's right to confidentiality. The right to confidentiality is specified in P.L. 92-255, Section 408 (The Drug Abuse Office and Treatment Act of 1972) as amended by P.L. 93-282 and in the Federal Regulations Part 2, Title 42, Confidentiality of Alcohol and Drug Abuse Patient Records (40 FR 27802). These regulations were published in the Federal Register of July 1, 1975 (Part IV). A detailed understanding of these regulations can be obtained through the self-instructional Confidentiality Course prepared by the National Drug Abuse Center.

The federal confidentiality regulations are applicable to any drug abuse prevention function that:

- In whole or in part is conducted by grant, contract, or otherwise by any federal agency;
- In whole or in part must be licensed, registered, approved, or authorized for the lawful conduct of business by any federal agency;
- Is assisted by funds supplied by any federal agency either directly by grant, contract, or otherwise, or indirectly by funds supplied by a federal agency to a state or local government through contracts, grants, general or specific revenue sharing; or
- Has been given tax exempt status by the Internal Revenue Service, or is allowable as an income tax deduction when contributions are made to it.

Where state regulations regarding confidentiality exist, they may supersede federal regulations only when the state regulation is more stringent. Otherwise no state law may either authorize or compel any disclosure prohibited by the federal regulations.

The federal regulations apply to all client records maintained by a program. "Records" is defined as "all oral communications and all written materials of the identity, diagnosis, prognosis, or treatment of past* and current clients." Thus, records and information covered would include those relating to a client's identity, diagnosis, prognosis, treatment, program participation, or other status information.

Protecting Client's Right to Privacy

Drug treatment programs are responsible for protecting the client's right to privacy by limiting disclosure, obtaining written consent from clients, establishing administrative procedures for confidentiality, and maintaining adequate security precautions.

A. Limiting Disclosure

The program must prevent access to client information by unauthorized persons. Only those individuals having a professional need to know, a legal right to know, plus written consent of the client may obtain client information, and then only when the specified conditions are met. The nature and extent of the information released to authorized individuals or organizations is restricted to whatever is minimally necessary to fulfill the purpose for the disclosure. Authorization does not mean "carte blanche" access to client information.

B. Obtaining Client Consent

The client must give his written, informed consent for release of information except under certain prescribed circumstances.

This is the situation that pertains to the release of information to third party payers. Informed consent means that the client fully understands the reasons for the disclosure, consents to the release of information, and that the consent is given freely, voluntarily, and without coercion. This is accomplished by having the client sign a written consent form specifying the following:

- Name of program making disclosure;
- Name or title of person or organization to which disclosure is to be made;
- Name of client;
- Purpose or need (reason) for disclosure;
- Extent or nature of information to be disclosed;
- Statement that consent is subject to revocation, by the client, at any time (unless the provider has already taken action based on having obtained consent) and the

* "Past clients" refers to individuals who received treatment as of 3/21/72 and whose case files are still open.

specific time upon which the consent will expire without express revocation or renewal;

- Date consent signed; and

- Signature of client and/or other signature as required.*

Examples of consent forms which you may want to use or modify follows this chapter.

Client Implications

Federal regulations permit the release of client information to third party payers only with the client's written consent. Such disclosure is limited to information that is reasonably necessary for the discharge of the contractual obligations of the third party payer. Where such third parties maintain records which identify the clients, they also must abide by treatment program confidentiality regulations. Therefore, they are also prohibited from unwarranted disclosure of client data. It is the responsibility of the treatment program to make certain that both public and private third party payers understand that they are subject to the confidentiality regulations.

Although this will rarely have any adverse effect on the client, he may be apprehensive about consenting to the release of information. Clients may be reluctant to consent to the release of information regarding their participation in a drug abuse treatment program because they fear that negative consequences will result from the disclosure.

Clients who are employed at the time they enter drug abuse treatment may fear that if their employers were to learn of their drug problem, they might be fired, moved to a less sensitive job, or that their potential for advancement might be diminished. Other apprehensions could be loss of a security clearance or social stigma. Welfare recipients may fear loss of this source of income. A woman on welfare may fear that she will be declared an "unfit" mother and her children taken from her.

Clients or parents of clients who have insurance that covers drug treatment may fear to release information to the insurance company because they might then be considered as a bad insurance risk.

Minors, in states having laws permitting them to obtain medical treatment without parental consent, might be reluctant to consent to release of information because they would not be willing to have their parents learn of their condition.

All of these fears are very real to some clients, and these situations do occur. It is the responsibility of the drug treatment program to assist the client in weighing the potential benefits and liabilities involved in consenting to release information. Remember, it is the client's right to refuse to give consent, for any reason, and he must not be coerced into giving it.

* If the client is a minor and there is no state law permitting minors to obtain medical services without the approval of a parent or guardian, the consent form must also be signed by the client's parent or guardian.

Program Implications

Adherence to the federal confidentiality regulations impacts a program in two basic ways -- it creates a need to develop appropriate administrative procedures and establishes the necessity of providing for the physical security of client records.

A. Administrative Procedures

The program should develop written procedures for regulating and controlling access to client information. These procedures should establish methods for processing information obtained at various data collection points (registration, counseling, medical examinations, methadone dispensary, etc.), limiting access to client information, and providing for accountability.

A single member of the staff should be designated to process inquiries and requests for client information. This staff member should be trained in the implementation of the confidentiality regulations. This individual should keep a record of everyone requesting information, the information provided, and the date on which it was requested.

All inquiries for client information should be in writing. Exceptions to this are bona fide medical emergencies and situations in which an individual on medication and in a situation where he is unable to provide written consent to his treatment program (e.g., traveling, hospitalized, incarcerated) requires continuation or modification of his medication. In all of the above type of situations a written record after the fact is required to document the disclosure. All inquiries and client consent forms must be in conformity with federal and state regulations.

Administrative procedures should also be developed to cover the specific instances under which client information may be released without consent. These are:

- In case of medical emergencies;
- For the purpose of scientific research, program audit or evaluation (as long as individual client identity is not disclosed by the recipients of this information and it is not used for action against any individual).
- If authorized by a court order. Note: a court order only nullifies the prohibition against disclosure, it does not compel disclosure.
- In the case of a minor who, in the opinion of the program director, lacks the capacity to make a rational decision on whether to consent to the notification of a parent or guardian, if such notification is necessary in order to reduce a threat to the well-being of the client or of another person. In such a case, the relevant facts may be communicated to a parent or guardian.

B. Physical Security

Programs must take appropriate precautions for the security of records. Records containing any information pertaining to clients must be kept in a secure room, or locked file cabinet, safe, or similar container when not in use. Access to files should be controlled by one staff member. The records should reside in a secure file (preferably a central file), and there should be a sign-out procedure if possible. Records should be signed out in the morning and returned to the secure file prior to the close of business each day. If a record is kept out overnight it should be stored in a locked file.

Authorization of Disclosure

General Consent Form

I,_____,
(client/patient name)

authorize_____
(name of program to disclose information)

to disclose to_____

_____

_____

_____
(name or title of person(s) or organization(s) to which disclosure is to be made)

the following identifying information from my records (specify extent or nature of information to be disclosed):

_____

_____

_____

The purpose or need for such disclosure is_____

_____

_____

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent (unless expressly revoked earlier) expires upon

_____
(specify date, event, or condition upon which it will expire)

Signature of Client/Patient_____Date_____

Signature of Witness_____Date_____

Signature of Parent, Guardian
or Legal Representative_____Date_____

Specify Relationship_____

DRAFT

Authorization of Disclosure
Notification Consent Form

I,_____,

authorize_____to notify and inform

_____

_____

_____

_____

of my presence in the facility, my status in treatment, and my general condition.

In addition, I authorize the acknowledgement of my presence in this facility to callers and visitors.

The purpose of the disclosure authorized herein is to provide information to parties personally interested in my whereabouts.

This consent may be revoked by me at any time except to the extent that action has been taken in reliance thereon. This consent (unless expressly revoked earlier) expires upon my formal discharge from this facility.

Signature of Client/Patient_____Date_____

Signature of Witness_____Date_____

Signature of Parent,
Guardian or Legal
Representative_____Date_____

Specify Relationship_____

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SPECIAL AUTHORIZATION FOR RELEASE

OF ALCOHOL OR DRUG ABUSE PATIENT RECORDS

I, _____, do hereby consent to and authorize _____ Hospital of _____, _____, to disclose to _____ information from the Hospital records relating to my identity, diagnosis, prognosis or treatment. I understand that the specific type of information to be disclosed includes _____ _____, and that the purpose or need for this disclosure is to _____ _____.

I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon, and that this consent will remain in force for a reasonable time in order to effectuate the purposes for which it is given.

Dated this _____ day of _____, 19 _____.

_____
Patient

Witnesses:

_____

_____

_____
Parent-Legal Guardian-Authorized Representative

NOTE To Recipient of Information: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Unless the records of your program are also subject to the Federal law, Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

CHAPTER 5

ADMINISTRATIVE AND FINANCIAL MANAGEMENT OF TREATMENT AND REHABILITATION PROGRAMS

ADMINISTRATIVE AND FINANCIAL MANAGEMENT OF TREATMENT AND REHABILITATION PROGRAMS

This section discusses program-related administrative and financial management implications of third party payments. These are policies and procedures, record keeping, development of a fee schedule, and billing and collection.

POLICIES AND PROCEDURES

Certain basic questions must be answered before a program can effectively implement a third party payments system; these are:

1. What are we trying to accomplish?

   Will the program undertake a major thrust toward third party billing and collections? What percentage of total revenue will the program expect from third parties? What is the sponsoring agency's expectations? What is the current experience with the client population? Is the program undertaking this action merely to meet federal, state, or local requirements or on the basis of well-planned financial management decisions?

2. What resources should be utilized?

   The answer to this question will depend a great deal on the answers given to question "1." Will there be the use of external resources in billing and collection activities? Are any resources available from the major back-up institution to the program, if any? Will a major investment be made in people and equipment in order to effect a billing and collection program?

   Who in the program's organization will be primarily responsible for this function?

3. How well must it get done?

   What will be the program director's and governing body's expectations of success? How will accomplishment be measured?

Answers to the above questions will provide the basis for a sound management structure for implementing a third party payments system.

Once the decision to attempt to garner third party funds has been made, basic management decisions related to all functions and activities associated with planning, organizing, and managing the collection of revenues from clients or third parties will be required. Specific policies related to the implementation and use of a third party payments system and procedures for executing them must be developed. These will relate to such factors as:

- Nature and extent of charges to be made for services rendered;
- Obtaining third party information from clients;

- Obtaining client consent to release information to third party;
- Protecting client information;
- Use of third party revenues;
- Meeting provider eligibility requirements;
- Maintenance of financial records; and
- Development of a billing and collection system.

PREREQUISITES TO AN EFFECTIVE FINANCIAL PLANNING SYSTEM

Certain fundamental organizational patterns must exist in the center before financial planning can become effective. These are:

(1) An organizational structure with responsibilities specifically defined and assigned.

(2) An accounting system and procedure paralleling the departmental organization of the center.

(3) The participation of responsible personnel at all levels of management in preparation of the financial plan.

(4) An understanding by all those involved in financial plan preparation of the service ideals of the institution, as well as of its financial goals.

(5) An adequate reporting system that provides current and reliable financial and statistical information to personnel responsible for preparation of the financial plan.

FUNDAMENTALS OF FINANCIAL PLANNING

A financial plan is a systematic presentation of estimates of revenue and expense for a specific period, prepared to reflect the anticipated expense allocations, and sources of patient or third-party revenue and the results thereof. Since the primary objective in financial planning is to guide the financial affairs of a health center to a desired goal, it is essential that anticipated cost of services demanded be carefully coordinated into a clear and concise financial program.

Participation by the department heads in the development of the financial plan will encourage acceptance of responsibility. Acknowledgment of their know-how in this respect, plus acceptance of them as part of the management team, can lead to better cost control. It is necessary that the forecasts be compared periodically with actual statistics, revenue and expense in order to determine the effectiveness of the plan. If this is not done, an important tool for control may be lost.

OBJECTIVES AND BENEFITS OF FINANCIAL PLANNING

Objectives: -- The fundamental objectives of financial planning are planning, forecasting, and controlling. The planning aspects include an intelligent estimate of:

(1) The volume and type of services to be rendered and the revenue to be derived therefrom.

(2) The number and types of personnel required and the cost.

(3) The volume and types of supplies needed and the cost.

(4) The fixed asset requirements and their cost, and the source of funds.

(5) Cash collections and disbursements, especially as related to the major third-party payers.

If comparisons and studies of actual operating experience are made periodically, the financial plan will serve as a means of controlling operating costs and services. These studies will also assist in evaluating the operation and in making reliable forecasts relative to the appropriate time for procurement, replacement or improvement of fixed assets.

Management Benefits: -- A complete financial planning system which coordinates planning and control is of benefit to management in numerous ways:

(1) The financial plan affords management an opportunity to examine intricate details of the many segments of the organization and evaluate their financial requirements.

(2) In the process of planning, influences outside the organization which may demand expansion and extension of services are brought to the attention of management for study and evaluation.

(3) The financial plan provides a device for establishing goals and setting policies that will influence their attainment.

(4) It aids in coordinating activities and responsibilities of employees at all levels.

(5) It provides a standard of comparison of actual results with estimates, which will assist in intelligent evaluation of the cost of activities, and point the way to future necessary controls.

(6) It stimulates cost consciousness throughout the organization.

(7) It assists management in anticipating working capital needs so that financial arrangements with alternate sources of funding may be made in advance and on the most favorable terms.

(8) By using the financial plan to forecast future financial position, management may plan for expansion and procurement of fixed assets

with reasonable assurance that funds to meet the costs will be available.

(9) Since the financial plan reflects the adequacy or inadequacy of the rate structure, it follows that with its use, together with cost analysis, management may pin-point areas of needed adjustment.

(10) Finally, the financial plan provides a continuous current check on the volume and cost of operations.

COMPOSITION OF A FINANCIAL PLAN

The total financial plan consists of three major budgets, which may be supplemented by other financial plans, estimates or forecasts. The three major budgets are:

(1) The Operating Budget: -- Consists of the accumulated estimates of operating revenues and expenses for a given period.

(2) The Plant and Equipment Budget: -- Consists of accumulated data for fixed assets that are expected to be acquired during a given period.

(3) The Cash Budget: -- Consists of accumulated estimates of monetary flow or working capital requirements and the source of funds for a given period.

Operating Budget: -- The operating budget consists of estimates of revenue and expenses and their anticipated results for a given period. Estimated future requirements and expenses for personnel, supplies and other items are collected by areas of responsibility, whether or not the activities are devoted to direct patient care and whether or not they are income-producing. It also includes estimates of patient statistics and of revenue resulting from routine and special services. The combination of estimated revenues and expenses and their results for a given period forms the operating budget.

Plant and Equipment Budget: -- A plant and equipment budget consists of estimates of the costs and determination of source of funds for replacements, improvements and additions to fixed assets that are expected to be acquired during the budget period. The cost of the estimated requirements, together with the anticipated dates of acquisition, should be reported in an organized manner for each area of responsibility. By combining individual reports, information regarding anticipated procurements, priorities and timing, as well as feasibility of acquisition, is provided.

Cash Budget: -- A cash forecast is an estimate of working capital requirements. It consists of the beginning balance, estimates of receipts and disbursements and the estimated ending balance for a given period. The period covered should correspond to that of operating and plant and equipment budgets. The cash budget should be prepared by estimating cash collections from patients as well as third-party sources, and applying against them cash disbursements required to meet obligations promptly as they come due. For convenience, it is desirable that cash required for operation, fixed assets and long-term obligations be treated separately and combined in summary to reflect the over-all requirements.

ESSENTIAL REQUIREMENTS FOR FINANCIAL PLANNING

Since the financial plan is used for planning, forecasting and controlling, it is essential that a "wholesome" environment exist in the center to ensure its successful use. This environment should include:

(1) A sound organizational structure.

(2) A functionally classified account system; (e.g., Wolf and Co.)

(3) Accumulation of adequate statistical data.

(4) Established financial plan periods.

(5) A formal financial plan; e.g., HSM-735.

(6) A formal report program.

Organization of Center: -- One of the prerequisites for effective financial planning is the development of a sound organizational structure within the center. This requires departmentalization in order that line personnel may be held accountable and responsible. Line employees should delegate work to subordinates in accordance with center policies. Department heads should expect the supervisor to carry out details of the plan as the administrator expects the department head to follow the general policy program. Along with this responsibility, the department head should be given authority to work within the framework of his department and require cooperation in following the over-all plan. Department heads cannot be held responsible if areas of control are not defined. Financial plans should assist management in identifying weaknesses in organizational structure.

Functionally Classified Chart of Accounts: -- A chart of accounts is an essential prerequisite to general accounting procedures. If the recommended chart of accounts has been properly installed and revenue and expense have been coordinated with activity and responsibility, the establishment of adequate procedures will be simplified. The organizational structure, the accounting system and the financial planning procedures should be designed in parallel and should be interdependent and complementary, thus contributing to a better understanding by key employees of their responsibilities and promoting more efficient utilization of personnel, supplies and facilities.

The extent to which the accounts may be categorized depends upon both the amount of detail considered necessary for control and the variety of activities in a department. Departments may be subdivided in larger centers to provide sufficient detail to show the responsibility of supervisors, or combined in smaller centers when the variety of activities does not justify separation. The chart of accounts should be altered and adjusted to show more or less detail as appropriate for each center so that it will provide all levels of management with the necessary information for planning and control.

Accumulation of Adequate Statistical Data: -- An organized system of statistical (non-monetary) data documenting the services rendered within each area or activity is as essential to successful financial planning as the functional account system. These data are used in the forecast and control phases of

financial planning procedures. Statistical data are sufficiently important to require formal written procedures describing the data to be gathered for each activity and the methods of accumulation. A brief discussion of statistics used in financial planning follows subsequently.

Financial Plan Period: -- Traditionally, business enterprises have used the accounting year as the period for which close review, investigation and evaluation is made of all facets of operations and their results. The financial plan should cover three full years of operation, since that is the longest period for which operating estimates can be made with a reasonable degree of accuracy. Long-range estimates may be necessary if plant fund requirements extend over a longer period of time. Ideally, the financial plan should be developed by combining monthly forecasts, rather than by breaking down yearly totals into monthly estimates. Annual data divided by 12 to arrive at monthly figures do not adjust for the effects of seasonal variations.

Formal Financial Planning System: -- A formalized process is essential to the preparation of the financial plan. It should include a definition of the responsibilities for the preparation of the departmental estimates and the accumulation of the various forecasts into a master financial plan. Individual departments should be responsible for the preparation of their operations and plant and equipment budgets. In small centers, the administrator may discuss financial problems with individual department heads; in larger centers, this responsibility could appropriately be delegated to the controller or fiscal officer.

Financial Planning Calendar: -- An integral part of the financial planning system is the financial planning calendar, which should indicate meeting dates for financial planning discussions. Financial planning should begin from four to eight months prior to the new fiscal year, because revisions may be necessary before final presentation. If specific dates are set for submission of preliminary and final departmental forecasts, adequate time must be provided for revisions at each stage. Year to year consistency in programming financial planning preparation activities promotes deliberate thought and reliable results.

Formal Report Program: -- Establishment, preparation and installation of financial planning procedures are essential; however, full benefits of a financial planning program cannot be realized without continuous awareness of financial planning implications of day-to-day transactions, and without periodic review of their accumulated effect. Formal accounting reports reflecting deficiencies and excesses should be prepared in comparative form by the accounting department at least once each month. Unusual circumstances may dictate their preparation at more frequent intervals. Key administrative personnel should be provided with copies of the entire report, and department heads should be provided with sections related to the activities for which they are responsible. Discussions with responsible personnel to determine why revenues or expenses are over or under the estimates will prove to be an indispensable aid to good management. Proper use of financial planning reports will simplify accurate projection of financial position at any future date in the budget year and, more importantly, at the end.

GENERAL PROCEDURES IN FINANCIAL PLANNING

Organization of Work: -- One method of organizing the work of financial planning is through the proper use of work papers and schedules. Wherever possible, standardized work-sheets should be used to facilitate summarizing data from the various departments. Use of standardized work papers will also assist in communications and understanding. Although individual circumstances dictate the form and content of work-sheets, basic information for future predictions would include past performance, present activity, proposed activity and notations of contemplated or definite changes.

Financial Plan Coordinating: -- Preliminary to preparing a financial plan, coordinating meetings should be held to discuss factors that affect volume of activity anticipated in the financial planning period. At these meetings, policies and recent changes in policy should be discussed, and planned expansion or changes in facilities or services should be brought to the attention of all concerned. Representatives from the medical staff should be requested to discuss changes in medical practice and their financial implications. Any facts that will assist in making more accurate forecasts should be discussed. These meetings will help to develop a better understanding of goals and to emphasize the importance of integrated effort.

After general policies and facts relative to services the center expects to render have been established, studies should be made of requirements for personnel and supplies. Statistics and financial data should be analyzed to observe trends. Since the current fiscal period will not have been completed, the accounting department should provide projections to the end of the current fiscal year. Employee participation in preparing the financial plan is a stimulant to efficient management, and employee responsibility for making it work promotes cost consciousness.

On a predetermined date, all departmental budgets should be submitted to administration for review and consolidation into preliminary estimates of income and other statements related to the general financing of the center. If changes are necessary, the departmental budget, with suggested revisions, should be returned to the department head as often as necessary until administrative concurrence is obtained. After all estimates have been approved, it should become the responsibility of the accounting department to prepare the formal financial plan.

The cash budget should be compiled by the accounting department, following the completion of the operating and the plant and equipment budgets. If the cash budget, based on estimates contained in the operating and the plant and equipment budgets, reflects a deficiency in working capital, adjustments in the other budgets may become necessary.

Since department heads are intimately acquainted with requirement for replacements, additions and improvements to plant and equipment, their estimates, together with suggested priorities, should be submitted directly to the administrator for evaluation and compilation of the recommended budget. Department heads are entitled to an explanation of any revisions from this point on.

A summary of the operating and the plant and equipment budgets should be submitted to the Board of Directors for discussion and approval. The information presented to the Board should consist of a brief narrative report, a condensed income statement, a summary of plant and equipment requirements and a program of available cash. The report should include only the significant factors considered in preparation of the forecasts and the anticipated results of the estimates on center services and finances. Condensed information focuses emphasis and attention on essentials and therefore expedites consideration of only important matters.

Individual Center Financial Planning Procedure Manual: -- Each center may find it desirable to develop its own detailed procedure manual, adaptable to its individual needs. Such a center procedure manual would serve a useful purpose, since oral instructions have proved to be unsatisfactory. The contents of the center manual would include the scope and purpose of the financial planning program, and the authority, duties and responsibilities of department heads for preparation and enforcement of their budgetary procedures. It should outline clearly the procedure for preparation, review and revision of the financial plan, as well as the period covered and the procedure for approval. Samples of reports should also be included in the manual. A check list relating to financial planning policy and preparation of the financial plan could be of considerable assistance to department heads in planning and forecasting.

STATISTICAL REQUIREMENTS

Availability of reliable information applicable to expected volume and scope of activities facilitates determination of accurate financial planning requirements. It is as true in ambulatory health centers as in industry and other types of enterprise that knowledge of past performance is essential to accurate prediction of future activities. Adequate statistical information therefore is essential to good financial planning. Whenever possible the utilization and cost experiences of similar centers should be employed for comparative purposes in your center's financial planning activities. The establishment and use of the approved AHC's reporting system is also encouraged.

STATISTICAL TECHNIQUES IN HEALTH CENTERS

Accounting techniques may be utilized appropriately in gathering certain types of statistical information; however, an excessive amount of time should not be spent in reconciling statistical inconsistencies that, as percentages, may be insignificant.

Units of Service: -- The concept of "Units of Service" is used to refer to units of measurement of health center activities. Obviously, the unit referred to as a unit of service will vary with the type of activity. For example, units of service for planning routine services to medical patients should be the number of physician visits, whereas the unit of service for radiology would be the films or examinations. For activities not related directly to services to patients, the unit of measurement might be the work hours required to carry out the activity, or the square feet of space to be serviced.

Time and expense may make it impractical to daily accumulate data related to a particular unit of service. Under these circumstances the statistical sample method may be used to obtain the desired information within a reasonable degree of accuracy. For example, if it is determined that a unit of service occurs uniformly for each week of the year, a detailed analysis could be made of the activity for a typical week. The monthly or annual rate could be reasonably estimated from this information. However, unusual and unpredictable volume variations in a given period, if they are of considerable consequence, may render the sample method unreliable. Highs and lows, as they relate to the average, must be properly evaluated if reasonably accurate statistical predictions are to be obtained.

Assignment of Responsibility: -- In the interest of accuracy, it is usually desirable to place responsibility for gathering statistics as close to the source of activity as practical. Number and types of physician visits, x-rays taken, laboratory tests performed, prescriptions filled, etc., may be determined by simple count of records maintained at department level. However, most of the information is available in the business office as a by-product of revenue records and, if automated tabulating machines are used for determining distribution of revenue, statistics may be compiled mechanically from these records with little extra effort. Regardless of where responsibility for compilation is assigned, it is imperative that current reliable utilization information be provided by or for each department.

Volumes of valuable statistical information may be accurately tabulated and maintained at the department level, and reports may be filed appropriately in the offices of responsible officers. This information, however, cannot serve its intended purpose unless it is summarized, analyzed and applied to related accounting and financial planning information. It is therefore necessary that responsibility for preparing finished reports be specifically assigned. Depending upon the size of the center, this responsibility could be assumed by the administrator or delegated to the controller, statistical clerk or fiscal officer. Since the value of these reports for current analysis diminishes with age, it is important that a deadline date for completion be established.

Procedures: -- Established written procedures are essential to gathering reliable statistical information. Procedures should be reviewed and revised periodically -- at least every two years -- so that they will be current and will contribute to efficient operation.

The most important aspect of statistical financial planning is interpretation. To adjust for external influences, the administrator and department heads should be familiar with pertinent indicators of economic activity and should keep intelligently informed about current research investigations and experiments. Care must be exercised in collecting and presenting material; otherwise incorrect interpretation may result in poor decisions. All data should be examined logically, with full knowledge of the background and without preconceived ideas or bias.

Statistics relative to the number of patients and patient visits may be accurately determined by use of accounting techniques. The importance of these statistics cannot be over-emphasized, for they are usually dependable barometers for making accurate predictions of over-all future demands for services.

Adjustments of Data: -- Statistical data received from each department should be systematically organized in carefully prepared schedules that include appropriate calculations of percentage ratios or graphs clearly reflecting the highs, norms, and lows on a comparative basis. It is understandable that many schedules will serve to support and confirm information related to fluctuations in service volume. It is therefore essential that these reports be prepared for both current analysis and future reference. Unexplainable and unexpected volume variations should be carefully analyzed by use of sampling, checking or counter-balancing methods, to determine and evaluate the cause. It must be determined that statistical data accurately reflects results of past experience before it can be safely used in making predictions of future activity.

SUMMARY

Knowledge and use of a structured Financial Management System in Ambulatory Health Centers are essential for concerted movement toward the maximization of third-party reimbursement. The active development and ongoing monitoring of a financial plan that reflects the financial implications of program planning decisions is critical to sound financial management. The new HSMHA Financial Plan (Form HSM-735) should be viewed then, not as a static OMB form, but as a dynamic document of value for internal planning and budgeting.

The challenge for administrators and fiscal officers of Ambulatory Health Centers is to immediately initiate the planning and budgeting processes needed for financial planning. The above considerations will beneficially contribute to such efforts.

RECORD KEEPING

The nature of the third party reimbursement mechanism is such that it requires paper. Insurance companies can't realistically pay for services unless they have evidence that the service was performed, that it is covered by the policy, that the recipient is eligible, and that the provider is qualified. The underwriter also wants to be sure that the charges are reasonable. Part of the input to this system will be from records identifying eligibility completed at the time of the client's entry into the program. An accurate record of eligible encounters must back up each billing also. This information could be maintained on the same record, one which has eligible services, payer, space to record visits and billings to the payers. Separate records should be maintained to record receipt of payments from payers.

Project requirements regarding the identification of clients who are eligible for third party assistance are given in section 50.105 of the Health Services Funding Regulations, as follows:

50.105

(e) An ongoing procedure to identify all persons served who are eligible for third-party reimbursement.

Discussion

Programs must establish and maintain standard registration and record-keeping procedures to identify and update information on the third party coverage and eligibility status of individual project users. These procedures should be contained in procedural manuals which are updated as needed. The procedures should include those needed to:

(1) Obtain accurate information on such items as age, residence, income, family size, present third party coverage, etc., without offending the dignity of the patient.

(2) Verify the information as frequently as needed (at least annually) to maintain accurate information.

(3) Inform patients of their rights and responsibilities in the area of third party coverage and assist them to apply formally for any applicable coverage(s).

Types of Records

A program must maintain written records in order to document clients' eligibility status, payer information (e.g., services covered, services provided and related costs), and billing and collection status.

The most obvious records are those that indicate what services were provided on what dates and by whom (encounter records). While it is good practice to keep this information anyway, it is certainly essential to prepare bills and to provide proof of documentation of charges to clients and third party payers.

Another useful set of records are those that document the third party reimbursement efforts in your center. You should establish an accounts receivable system to show which bills have been paid and which have not and a system that will tell you whether or not any given client has been checked for third party eligibility.

The third area might be called the control area. This set of records should show your third party reimbursement payments and their percentage of your total income. It should include the different sources of payment. This information will help you analyze your cost structures to evaluate and update your rate schedules, and is necessary to evaluate and monitor the efficiency of the third party reimbursement system. Properly maintained records and documents are good program and accounting practices. If your program has been a federally funded program in the past, you will find that the record keeping related to third party reimbursement is no more demanding and offers greater relevance to your financial management requirements.

Encounter Records

A clear, accurate account of every encounter with a client must be recorded. This is beneficial to both your program and the client.

Listed below are guidelines designed to make your work more efficient. Each documentation should have certain characteristics. Check to see that each entry:

- Is legible. If necessary, print your entries. Data should be recorded in ink, not pencil.

- Is specific. Include specific data rather than vague, general information. Avoid entries such as: "Discussed with Thelma her financial situation. Seems to be OK for now." Instead, describe her financial situation; explain why it is OK. What does "now" imply?

- States the purpose of contact or attempted contact. Again, avoid entries such as: "Tried calling John. No answer. Will try again." A better way of recording your attempt at contact would be: "Tried calling John (6/13; 1:30 p.m.) to ask that he come in to sign release. We need to contact his employer, A & D Delivery, regarding the company's health services benefits. No answer. Will try again tomorrow."

- Provides continuity. Read previous entries before adding a new one. In this way, you will ensure that each task is completed. Let's consider John (from #3 above) again. The next entry should show a follow-up on the phone call; for example: "Called and reached John (6/14; 9:00 a.m.). Asked him to come in to sign release form so employer can be contacted. Will meet with me tomorrow at 3:15 p.m."

- Records dates and times of each contact.

- Is clear. Re-read your documentation. Is it clear and precise? Would another staff member be able to understand it? Would you be able to understand it six weeks from now?

- Is signed by you. If other staff members need further information regarding an entry, they should know who to talk to.

SUMMARY

Use of the third party payment system will, indeed, place additional demands upon your program. Intake procedures will probably have to be revised. Extra care in documentation and validation as well as strict adherence to the use of release forms will be required.

But the incorporation of third party payments into your program can provide the opportunity for self-assessment. Besides supplying needed revenue, it offers a chance to institute policies and procedures that can enhance the efficiency and credibility of your program.

COLLECTION PROCEDURES

There should be written policies regarding the entire collection process and strategies for collecting outstanding indebtedness and dealing directly with self-paying clients. Again, the cash flow is involved, especially in programs that may come to depend heavily upon third party party reimbursements. Money collected is available to cover the cost of services being provided at the time.

Collection Policy

There should be a written collection policy that will address the following basic issues:

- When an account should be followed up;
- How the follow-up will be accomplished;
- Who should do the follow-up; and
- Who makes the decision that an account is uncollectable.

Follow-up

Follow-up on claims submitted to third party payers may be necessary due to delays in receiving reimbursement. Payment of a claim may be delayed for a reason as simple as a mistyped policy number or a misspelled policyholder's name, or as serious as a question about the eligibility of the service itself or your program's legitimacy.

All follow-up should be conducted by letter in order both to formalize the inquiry and provide a record of the action taken.

Your letter should include all pertinent information to help the third party locate your claim.

The most important items to include are 1) the claim number (from the claim form), 2) the policy and/or group number, 3) the date on which you sent the claim, 4) the name of the insured party (not necessarily the client), 5) the person served, 6) his status--inpatient or outpatient--(there may be different departments to handle each type of claim), and 7) the dates services were given.

COST FINDING PROCEDURES

Introduction

The purpose of this procedure is to determine the unit costs of the services delivered by a treatment program. This information can be used as a guide in setting fees for services, as a measure of program efficiency and to determine the extent to which the reimbursement rates available from third parties are covering the cost of the services. It meets the criteria of Administrative Order 1.42.

The procedure described below consists of four essential steps: defining the units of service, allocating direct costs, allocating indirect costs and calculation of unit cost.

Defining Units of Service

Before unit costs can be calculated, standard units of service must be defined. A unit of service is merely a measure by which the quantity of services provided by a program can be defined. A different unit may be employed for each distinct service provided by a program. Typically the scope of services delivered by a treatment program can be defined by a few units of service. The units may be as broadly defined as suits the users' purpose. The only requirement is that the units be mutually exclusive.

The services provided by a program may be measured by many types of units but for illustrative purposes the following scheme is provided:

Counseling Visit:	Any face-to-face therapeutic encounter between a counselor and a client.
Dispensing Visit:	Any face-to-face encounter between a staff member and a client in which methadone is dispensed to the client.
Therapeutic Community Day:	The room, board and treatment cost of one client remaining in the residence for one night.
Day Care Day:	The board and treatment cost for one client to stay in the day care program for one day.
Intake:	The diagnostic work-up, evaluation and registration performed upon admission or readmission to a program. (may include physical examination)

Since the complexity of the cost finding procedure is related to the number of different units of service used to describe the services delivered, the administrator should use as few different units as possible when performing the cost finding initially.

If only one unit of service is employed, the cost finding procedure is a simple matter of dividing the total program cost by the number of units of service delivered. e.g., $\frac{\text{total therapeutic community cost}}{\text{no. of therapeutic community days.}}$

When more than one unit of service is used, it becomes necessary to distinguish between direct and indirect costs and to allocate both appropriately to the respective units of service.

Costs

The costs of delivering services may be broadly classified as direct or indirect. Direct costs are those which are clearly associated with a treatment modality and with the delivery of a specific unit of service. For example, the cost of a counselor's time spent in counseling clients would be considered a direct cost of producing the unit of service called a "counseling visit".

Indirect costs are those which cannot be clearly associated with the delivery of a specific unit of service but are nonetheless necessary to support the delivery of services. Indirect costs may be classified into two categories: general and administrative and overhead. General and administrative costs (G&A) are those which cannot be associated with a single treatment modality but may cut across modalities. Overhead costs are those which can be associated with a treatment modality but not a specific unit of service. For example, the salary of the administrator of a clinic within the program would be classified as an overhead cost. In a program consisting of only one modality G&A and overhead costs may be considered synonymous and there is no need to distinguish the two.

Allocating Direct Costs

Direct costs may be allocated using a matrix such as that presented in exhibits 1 and 2 at end of Chapter.

To complete exhibit 1 perform the following:

1. List all persons on the payroll during the time period of interest.

2. Classify each position as "M" if it is an integral part of a modality and "A" if it is not an integral part of a treatment modality but may encompass two or more modalities.

3. Enter the total cost per year for each position, i.e., the salary and fringe benefit cost for each employee. If an employee is shared with another agency enter only your agency's share of his salary and fringe benefits.

4. For each employee enter the percentage of total work time spent on each unit of service. Time that is not spent in face to face contact with a client or significant others pertaining to the client or in telephone calls or written communication pertaining to a client should be entered as a percentage under the category of G&A if the position is classified as an "A" position in step 2 or under the category overhead if the position is classified as an "M" position.

5. For each employee multiply the total cost per year by the percentage of time spent of a given service unit and enter the product under the appropriate service unit cost.

Hints:

- The percentage of work time spent by an employee on each unit of service may be derived in various ways, for example: a study of time sheets, interviews of employees, direct observation or judgmental estimates of experienced supervisors.

- The sum of the percentages of work time for each employee should be 100%. (even in the case of an employee who works less than full-time) The final column in exhibit 1 is included as a means by which to check that the percentages for any employee add to 100%.

  Unpaid volunteers (hours only) should be included if the purpose of the cost finding is to calculate rates for purposes of reimbursement by third parties.

- In cases where an employee's time is split between modality specific and non-modality specific activities as for example when a physician administers the treatment program and provides intake physicals, this distribution of time should be reflected in the percentages entered in service unit and G&A columns.

Exhibit 2 is a matrix for allocating "other" that is non-staff costs.

To complete exhibit 2 perform the following:

1. Enter the total expenditure for the period in each applicable expenditure category.

2. Any cost or cost category which cannot be clearly associated with a specific delivery modality should be classified as a G&A indirect cost.

3. Any cost which can be associated with a treatment modality but cannot be associated with production of a single unit of service should be classified as overhead. For example, the rent at a methadone clinic would be considered a direct cost. In a residential modality food would be considered a direct cost but utilities an overhead cost.

4. Only a few of the accounts listed in Exhibit 2 can be considered to be direct costs.

Allocating Indirect Costs

Indirect costs are by definition costs that are not readily associated with a specific unit of service. Most of the non-personnel costs in treatment programs are of this sort. Some method of allocating these costs must be used if unit costs are to be computed. These methods may be detailed or relatively simple but all are merely convenient ways for assigning costs that are not readily divisible by unit of service. Hence, there is an element of arbitrariness in any allocation procedure.

The procedure suggested below is simply that indirect costs be assigned to units of service in the same proportion as the direct cost of that unit of service bears to total direct costs.

Exhibit 3 is a matrix for allocating indirect costs.

To complete exhibit 3 perform the following:

1. Enter in column 1 the direct cost for each service unit as completed in exhibit 2 and compute a total for all service units.

2. For each unit of service divide the direct cost in column 1 by the total direct cost for all service units and enter the resulting percentage in column 2.

3. For each unit of service multiply the total indirect cost from exhibit 2 by the percentage of total direct cost in column 2 and enter the product in column 3.

4. Add columns 1 and 3 and enter in column 4.

Calculating Unit Cost

Unit costs are merely total cost (direct and indirect) divided by the number of units of service delivered.

Exhibit 4 is a matrix for computing unit cost.

To complete exhibit 4 perform the following:

1. For each service unit enter the total cost from column 4 of exhibit 3.

2. For each service unit enter the number of units delivered during the same period of time applicable to the cost data.

3. For each service divide the number of units into the total cost and enter the dividend.

Exhibit 1: Personnel Cost Allocation Worksheet

Same As
Administrative Order 1.42
Service Center

			Direct:										Indirect				
			Service Unit A		Service Unit B		Service Unit C		Service Unit D		Service Unit E		Overhead		General and Administrative		Total
Employee Position	M/A	Total Cost/Year	% Time	Cost	% Time	Cost	% Time	Cost	% Time	Cost	% Time	Cost	% Time	Cost	% Time	Cost	% Time
Administrator	A	16,000													100	16,000	100%
Counselor	M	10,000	10	1,000			50	5,000					40	4,000			100%
Total			NA		NA		NA		NA		NA						NA

Exhibit 2: Other Cost Allocation Work Sheet

Cost: Category	Total for Period	Direct Service Unit A	Unit B	Unit C	Unit D	Unit E	Indirect Overhead	G & A	Total Indirect
Supplies									
Equipment									
Repairs									
Insurance									
Subscriptions									
Recruitment									
Conferences									
Travel									
Food									
Telephone									
Utilities									
Building Rental									
Equipment Rental									
Printing									
Workmens Comp.									
Unemployment Comp.									
Consultants									
Other Purchased Services									
Total Other									110
Total Personnel									
Grand Total									

102

103

Exhibit 3: Indirect Cost Allocation Worksheet

	(1)	(2)	(3)	(4)
Service Unit	Direct Cost	Percent of Total Direct Cost	Indirect Cost	Total Cost
A				
B				
C				
D				
E				
Total		100		

103

111

112

Exhibit 4: Unit Cost Computation Worksheet

Service Unit	Total Cost	Number of Units	Cost Per Unit
A			
B			
C			
D			
E			

THE FOLLOWING FORMS ARE INTENDED TO ASSIST IN DEVELOPING BILLING CAPABILITY. THEY ARE NOT INTENDED TO REPLACE YOUR PRESENT METHODOLOGY.

ENCOUNTER FORM		Form Number:		
Client Name: CECIL FISHER		Client Number: C C C [illegible] [illegible] [illegible] [illegible] 1		
Third-Party Payment Source: TITLE XIX	Insurance Number:	Date of Service:	Month: 01	Day: 21 Year: 76

Service Provided	Number of Units	x	Cost Per Unit	Total Charges	Provider Number
Intake Interview (Outpatient Methadone)					
Admissions Interview (Residential Drug Free)					
Intake Interview (Outpatient Drug Free)					
Intake Physical Examination	1		$43	$43	002
Review of Physical Examination					
Group Counseling					
Morning Session					
Individual Counseling					
Case Review by Supervisor and Counselor					
Family Counseling					
Case Review by Entire Staff					
Case Review by Psychiatrist					
Urinalysis					
Methadone Dispensing	1		1 24	1 24	003
Other Drug Dispensing					
Vocational Rehabilitation Counseling					
Relatives' Counseling					
Occupational Therapy					
Recreational Therapy					
Counseling by Psychologist					
Counseling by Psychiatrist					
Medical Review					
Counseling for Support Service					
Referral to Support Service					
Food					
Transportation					
Total Charges				$5 67	
Discount (where applicable)					
NET DUE FROM PATIENT				$5 67	

To Be Completed In Duplicate By Primary Provider

Detached Size: 5½" x 8"

GEORGE FISHER
POST OFFICE BOX 2
BETHESDA MARYLAND

Billing Date: _____ Number: _____

Indicate Amount Paid: $_____

Detach and Return Upper Portion With Your Remittance

STATEMENT OF ACCOUNT

Date	Folio	Detail	Charges					Balance Forward →	
			Individual Counseling	Methadone Maint. and Detoxification	Group Counseling	Intake Procedure	Other	Credits	Balance
11/24/76	AC-1	Physical Exam Medication		1.34			34.31		35.65

Please Pay Last Amount In Balance Column →

107

116

117

Card Size: 5" x 8"

ACCOUNTS RECEIVABLE LEDGER CARD										Name: GEORGE FISHER	
Insurance Coverage: TITLE XX										Address: POST OFFICE BOX 3 BETHESDA MARYLAND	
			Respon-sibility	Charges						Balance Forward →	0
Date	Folio	Detail	Center	Individual Counseling	Methadone Maint. and Detoxification	Group Counseling	Intake Procedure	Other		Credits	Balance
[illegible]			01		1.25			94.39			95.64

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BILLING JOURNAL

	Date	Client	Invoice Number	(1) Total Billed	(2) Individual Counseling	(3) Methadone Maintenance and Detox.	(4) Group Counseling	(5) Intake Procedure	(6) Other	(7)	(8)	(9) G/L Account Number	(10) Responsibility Center and Description
1	10/1	CECILE FISHER											
2	10/2	MABLE KING											
3													
4													
5													
6													
7													
8													
9													
10													
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120

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MORE USEFUL TERMS

ACCESSIBILITY	Those qualities of a facility or service that affect an individual's ability to make use of that facility or service. These qualities relate to, but are not limited to, capacity, location, eligibility requirements, costs, and visibility.
ACCREDITATION	The process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards.
ADMINISTRATION	Refers to the general management and business aspects of a program as opposed to direct client services.
ADMISSION	The point of completion of the intake process at which time the client may receive the full services of the program.
AGENT	An individual or firm authorized by an insurance company to sell policies and collect premiums.
ALLOWANCE	Payment under an insurance policy, same as benefits.
AMBULATORY CARE	Health services rendered to persons who are not confined overnight in a health care institution. Ambulatory care services are often referred to as "outpatient" services.
ANCILLARY CHARGE	A fee for service rendered upon request of the primary provider by an auxiliary service unit (e.g., laboratory) and not included in the basic charge made by the individual provider.
APPLICANT	An individual seeking admission to a program. Upon admission to the program, an applicant becomes a client (or patient).
ASSESSMENT AND REFERRAL PROGRAM	As defined by the Joint Commission on Accreditation of Hospitals: a program with a staff, budget, facilities, and other resources that functions under a defined set of policies and procedures related to assessing the needs of drug abusing individuals and referring such individuals to appropriate treatment resources. An assessment and referral program is often, though not necessarily, operated for the purpose of doing intake processing for several independent drug abuse programs or for an agency operating several programs.
ASSIGNMENT (OR ASSIGNMENT OF BENEFITS)	A procedure by which the client assigns his right to reimbursement to the provider. The provider then collects directly from the third party.

AUTHORIZED INDIVIDUALS (OR ORGANIZATIONS)	Individuals or organizations having a professional or legal right to access client information. Such authorizations are limited to the minimal amount of such data which is necessary.
BAD DEBT EXPENSE	When services are provided on credit (a billed basis), there are almost always some clients who do not pay. In order to account for this, a certain percentage of the revenue, as it is generated, is reserved for bad debt expenses. For third parties, it is customary to have co-payments and deductibles; and since many programs do not bill clients for "their share," these expenses must be accounted for.
BENEFICIARY	Person named in an insurance contract to receive all or part of the benefits.
BENEFITS	The specific types of services and/or treatment that will be reimbursed by a third party payer.
BENEFIT PERIOD	Defined under Medicare law as "a spell of illness." More specifically, it begins when the patient is admitted to a hospital and ends when he has been out of any medical facility for 60 consecutive days.
BENEFIT SCHEDULE	A list of benefits to be paid to the insured under his policy. For example, a surgical benefit schedule would list maximum benefits for a variety of surgical procedures: e.g., colostomy: $250.00; hernia repair: $150.00.
BENEFIT STRUCTURE	A description of the services for which a third party payer will provide reimbursement when the services are rendered to individuals who are eligible for coverage under the payer's plan. Usually this description is in the form of a list of specific reimbursable services; occasionally it may be in the form of the statement that all services of a general type (e.g., physicians' services) are covered except certain specified exclusions.
BILL	An itemized list of charges owed by the client or his insurance company for services rendered.
BINDER	Temporary insurance pending execution of the policy contract.
BUDGET	A program's plan for the expenditure of funds to support the services provided for a specified period of time.
BUREAU OF HEALTH INSURANCE (BHI)	A bureau of the Social Security Administration that administers the Medicare health insurance program.
BUY-IN	An option granted to states to enable them to use federal Medicaid funds to buy Medicare Part B coverage (outpatient) for Medicaid recipients eligible for Medicare coverage

	as well. This buy-in reduces Medicaid responsibility to the deductible and coinsurance amounts for services covered under Medicare.
CANCELLATION	The termination of an insurance contract before the end of the policy period by either the insured or the company.
CAPITATION	A prospectively determined payment rate per individual and per unit of time for specific health services.
CARRIER	The technical designation for an insurance company because it carries the risk and pays for the necessary services as a third party.
CASH FLOW	The stream of cash receipts and disbursements generated in the course of program operations. The combined effect of these streams represents the net cash status of the program.
CATEGORICALLY NEEDY	The descriptive designation of one of two classes of Medicaid-eligible persons (see Medically Needy). Categorically needy individuals receive Medicaid benefits because they are eligible for welfare benefits defined categorically for the blind, the disabled, the aged, and families of dependent children. All states participating in Medicaid must cover required services for the categorically needy.
CERTIFICATION	The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.
CHAMPUS	Civilian Health and Medical Program for the Uniformed Services, a program providing medical services to military dependents and retired military personnel.
CHRONIC ILLNESS	A prolonged or lingering illness usually not approaching a critical condition.
CLAIM	A demand that an insurance company pay for a loss covered by an insurance policy.
CLIENT	An individual who is entitled to receive the full services of a program.
CLIENT CASE RECORD	A record maintained on all applicants and/or clients containing the history of the individual's association with the program.
CLIENT SERVICES	Services designed to meet the client's treatment or rehabilitation needs.

CO-INSURANCE (A FORM OF PARTIAL COVERAGE)	The insurance company and the insured each pay a percentage of the loss. For example, the insured may pay 20% and the insurance company 80% of the loss after the deductible up to a set limit.
COMMISSION	The fee paid to the insurance agent who sells the insured a policy. It is paid by the company out of the premium and is usually a percentage of that premium.
COMPREHENSIVE REHABILITATION PROGRAM	As defined by the Joint Commission on Accreditation of Hospitals: a program with a staff, budget, facilities, and other resources that functions under a defined set of policies and procedures designed to achieve permanent changes in an individual's drug taking behavior and to ameliorate those problems resulting from his or her drug use. A comprehensive rehabilitation program provides the following client services: activities, legal assistance, mental health, physical health, social and vocational rehabilitation.
CONDITIONS	Provisions in the policy pertaining to the promises of the insurer, the obligations of the insured, the rights of both parties, and the limitations or exclusions of the policy.
CONFIDENTIALITY	The process of safeguarding client information so as to prevent unauthorized disclosure.
CONTRACT HOLDER	The insured individual or, with a group policy, the employer or organization.
CONTRACT YEAR	The 365-day period during which an insurance policy is in effect.
CONTRIBUTORY PLAN	Group insurance where covered persons pay a portion of the premium, usually through payroll deduction. (See Noncontributory Plan.)
CONVERSION	Changing from one type of policy to another. For example, converting from a group to a private policy after retirement.
CONVERSION PRIVILEGE	A clause giving the insured the right to a different type of policy without medical examination.
CONVERSION RIGHTS	See Conversion Privilege.
CONVERTED CONTRACT	A policy issued after the conversion privilege is exercised.
COST CENTERS	Functional areas used in categorizing costs incurred in providing treatment or services.
COVERED SERVICES	Those medical services for which payment will be made under an insurance policy.

CREDENTIALING	A generic term encompassing accreditation, certification, and licensing.
DEDUCTIBLE	A specified dollar amount, which an individual is expected to pay personally toward the cost of his health care services during a designated time period before being eligible to receive reimbursement from a third party source.
DIRECT CLIENT	Any form of client self-payment to the project for services rendered. Direct client payments may be either for the full cost of services rendered or for some predetermined portion of those costs.
DIRECT COSTS	Costs that are incurred only when resources are consumed such as medical supplies and equipment used in the direct treatment of a client.
DISBURSEMENT	The cash outflow (payments out) that occurs in payment for the acquisition or retention of a program resource.
ELIGIBLE CLIENT	A client who qualifies for benefits under third party reimbursement plans such as Medicare, Medicaid, or private insurance plans.
EMERGENCY PROGRAM	As defined by the Joint Commission on Accreditation of Hospitals: a program with a staff, budget, facilities, and other resources that functions under a defined set of policies and procedures designed for the treatment of acute, severly debilitating and/or life-threatening conditions.
ENCOUNTER	A face-to-face contact between a client and a program staff member providing some form of treatment or rehabilitative service.
ENCOUNTER FORM	A form on which medical and billing information regarding an encounter is entered by the provider.
EPSDT	Early Periodic Screening, Diagnosis, and Treatment (of conditions found)--a program required to be included and covered in state Medicaid plans in which screening, diagnostic, and treatment services are provided to all Medicaid-eligible persons under the age of 21.
EXPENDITURE	A cost incurred either through the commitment of credit or the disbursement of cash.
FEE-FOR-SERVICE	A procedure for charging clients or third party payers in which different fees are charged for different services, on the basis of a schedule of fees set by the organization providing the service.

FEE SCHEDULE	May be either the fee-for-service schedule established by a provider or a payer's list of acceptable fees or maximum payments for specified medical procedures.
FISCAL AGENT	A company or agency responsible for reimbursing providers for covered services to eligible individuals. The responsibility of a particular fiscal agent is normally limited geographically (e.g., a particular county, state, or region).
FIXED COSTS	Cost incurred regardless of whether resources are consumed. These costs (such as rent expense, maintenance, heating) do not vary with utilization.
FOLLOW-UP	Actions related to receiving payment for an outstanding bill.
FOLLOW-UP BILL	A bill submitted to the same party (client or third party payer) subsequent to an initial bill.
GROUP INSURANCE	Coverage for a number of people, usually employees of one firm or members of an association or organization.
HEALTH CARE FACILITIES	Organizations and agencies established for the purpose of serving particular health care needs, including hospitals, clinics, health training and research institutions, nursing homes and related long-term care insitutions.
HEALTH CARE PROVIDER	See Provider.
HEALTH CARE SYSTEM	An interrelated group of resources providing services that promote or protect health. These resources include facilities, equipment, material, manpower, and knowledge.
HEALTH MAINTENANCE ORGANIZATION (HMO)	A prepaid, capitation-based comprehensive health care system providing services to voluntary, enrolled beneficiary population.
IDENTIFICATION CARD	A card issued to the insured by his insurance company. It carries the identifying policy numbers and the type of coverage held by the insured.
INDEMNITY CARRIER	An insurance company or group that agrees to assume some risk for its subscribers at some predetermined level.
INDEMNITY HEALTH INSURANCE PLAN	A form of insurance that guarantees against financial loss up to the amount of the limits of the insurance policy. Payment is related to the illness suffered by the insured, not to the treatment or services received.
INDEMNITY PLAN	An insurance plan that pays for specific, named situations. Medical insurance plans that pay specified amounts for

	designated services only are an example of this type of insurance.
INDIVIDUAL POLICY	Coverage held by an individual as opposed to a group policy.
INDIVIDUAL PROVIDER	A physician or other health care worker who provides treatment or service to clients. An individual provider may operate independently or as a staff member of a program.
IN-HOSPITAL	A term used in policies to describe location of services (e.g., in-hospital doctors' visits as opposed to office visits).
IN-KIND CONTRIBUTION	Resources other than cash contributed by (1) the provider organization, (2) other public agencies and institutions, and/or (3) private organizations and individuals. Such resources can include the value of real property and equipment and of goods and services directly benefiting, and specifically identifiable to, the grant program.
INPATIENT	A person receiving medical care who has been formally admitted to a hospital.
INSTITUTIONAL PROVIDER	An agency or organization in which physicians and other health care delivery workers provide services to clients.
INTAKE	The process of determining if an applicant is eligible for admission to a program.
INTERMEDIARY	The fiscal agent authorized by Medicare to administer reimbursement for Medicare Part A. Under certain, specified conditions, an intermediary must also perform the functions of a carrier in making Part B reimbursements.
LICENSURE	The process by which an agency of government grants permission to persons meeting certain qualifications to engage in a given occupation, or through which the agency grants permission to institutions to perform specified functions.
LIMITATION	The maximum amount a policy will pay for a given accident or illness.
LIMITED SICKNESS POLICIES	Insurance policies that cover only a specific disease such as cancer. Also called "dread disease contracts" or the "polio disease indemnity" because of their original purpose.
MAJOR MEDICAL	A type of supplementary policy offering expanded benefits to the subscriber. These benefits usually take effect

	after a specified amount of money has been paid out by the regular policy for a single accident or illness and cover 75 to 85 percent of the remaining bills.
MAXIMUM BENEFIT	The top fee that the insurance company will pay for a specified disability or procedure.
MEDICAID	Title XIX of the Social Security Amendments of 1965--A federal-state program under which the categorically and medically needy are assisted in paying their costs of health care. The federal legislation authorizes federal grants to states to cover varying shares of the costs of designated medical services provided.
MEDICAL SERVICES ADMINISTRATION (MSA)	The federal agency responsible for administering the Medicaid program in the Social and Rehabilitation Service of the Department of Health, Education and Welfare.
MEDICALLY NEEDY	One of the two classes of Medicaid eligibles. The medically needy are those able to pay routine living costs but unable to pay for drugs, medical products, or services. This coverage is optional for the states.
MEDICARE	Title XVIII of the Social Security Act Amendments of 1965--a hospital insurance program for the aged and supplementary medical insurance benefits for ambulatory care. Two types of coverage are available: as a general rule, Medicare Part A deals with inpatient care, Part B (Supplementary Medical Insurance) with outpatient care. Part A is automatic in that everyone eligible is included. Part B coverage is extended only when the patient enrolls and pays a monthly premium.
NO-PAY CLIENT	A client who is not charged for the services provided to him. (see "sliding scale")
NONCONTRIBUTORY PLAN	A group insurance plan where the employer pays the entire premium for the employees.
OUTPATIENT	A person receiving medical care from a hospital or clinic while residing at home. (See also Ambulatory Care.)
PAID IN FULL BENEFIT	Insurance company pays the entire cost of the claim.
PARTIAL PAY CLIENT	A client who is billed less than the normal charge for a service because his financial resources are limited (see Sliding Fee Schedule).
PARTICIPATING DOCTOR	A doctor willing to process claims to, and accept payment from Medicare, Medicaid, and private insurance companies.

PATIENT	See Client.
POOL	Insurers reduce the risk that actual claims might exceed expected claims by forming exposure pools; that is, combining with other companies to pool risks.
PRACTITIONER	One who practices an occupation or technique. In medicine it generally refers to a doctor, but it may also refer to an expert in certain medical areas such as a pediatric nurse.
PRE-EXISTING CONDITION	An injury or illness that existed before insurance became effective.
PREMIUM	A sum of money paid by a private individual or a group of individuals to an insurance company so that he (they) may be insured by the company for a specified length of time.
PREPAID GROUP PRACTICE	An organization composed of physicians and other health professionals who contract to provide a wide range of preventive, diagnostic, and treatment services on a continuing basis for enrolled participants.
PROHIBITED RISK	Person considered uninsurable for occupational or personal reasons.
PROOF OF LOSS	Written proof covering the occurrence, character, and extent of the loss for which claim is made, usually submitted on forms furnished by the company.
PROVIDER	The doctor, hospital, or treatment center that furnishes medical services to a client.
PROVIDER STATUS	Denotes formal recognition of a provider (individual or institutional) by third party payers as eligible to collect reimbursement for services rendered.
PROVISIONAL RATE	A tentative premium subject to a refund or additional payment as indicated by experience with the risk. Also known as retrospective or tentative rating.
RECEIPTS	The cash intake that results from revenue received from third parties or clients for services or prepayments for services to be rendered. Also refers to the proceeds from external sources such as grants, donations, and loans.
RECORDS	All oral communications and written materials related to the identification, registration, diagnosis, prognosis, treatment, or any other form of assistance provided to past and current clients.

REGISTRATION	The process by which qualified individuals are listed on an official roster maintained by a governmental or nongovernmental agency.
REINSTATEMENT	The renewal of an insurance policy following its cancellation due to nonpayment of premiums. This renewal is accomplished by payment of the required premium and submission of evidence of insurability to the carrier.
RELATIVE VALUE SCALE	A method of determining fees for services; the most common services are listed and a unit value based on time required, complexity, and other criteria is assigned to each. In the 1971 Massachusetts Relative Value Scale, for example, a simple injection is rated as 8 units, an initial comprehensive history and physical examination of an adult is rated at 70 units, and a cardiac catheterization procedure is rated at 350 units. These units are frequently converted to dollar fees by multiplying by a constant "conversion factor." In the example above, application of a $1.25 conversion factor would result in fees of $10, $87.50, and $375, respectively, for the three services.
RELEASE FORM	A form, signed by the client, which permits the program to release information regarding the client to relevant third party payers. The release form must designate the type of information to be released and to whom it is being sent.
RESOURCE	A generic term used to describe any type of manpower, facility, equipment supply, or service having a monetary value (or "cost"), and required by the program in order to function.
RIDER	An agreement not contained in the basic policy contract that may be attached to the policy to extend or restrict coverage to fit individual circumstances. Also called an endorsement.
SELF-PAY	A bill for services that is the total responsibility of the client.
SERVICE UNIT	A measure of the activity or production of a particular unit of the program. For example, a laboratory's service units are the number of tests performed and a pharmacy's service units are the number of prescriptions filled.
SHORT-TERM DETOXIFICATION PROGRAM	As defined by the Joint Commission on Accreditation of Hospitals: a program with a staff, budget, facilities, and other resources that functions under a defined set of policies and procedures. It's purpose is to effect the systematic reduction in an individual's physical dependence on drugs; such reduction is usually accomplished within 30 days.

SLIDING FEE SCHEDULE	A fee schedule under which the fee charged the client for services varies with his ability to pay. When this type of fee schedule is used, clients who are not covered by a third party source are classified as "full pay" (pay 100% of the charges), "partial pay" (pay between 1% and 99% of the charges), and "no pay" (program bears the entire cost of services and receives no reimbursement).
SMI	Supplementary Medical Insurance. (See Medicare Part B.)
STATISTICAL VISIT CHARGE	A flat charge for each client encounter irrespective of the type of service rendered. The given charge is generally developed by determining an average cost-per-encounter and using this figure as the rate charged for every type of encounter.
SUBSCRIBER	The person or organization that obtains insurance coverage. Same as "insured."
THIRD PARTY PAYER	An organization or individual other than the person receiving treatment or rehabilitative services that pays for all or part of such services.
THIRD PARTY PAYMENTS/REIMBURSEMENTS	Payment (for service received by an individual) by an organization, agency, or individual who is neither the receiver nor provider of the service.
TOKEN PAYMENT	A partial payment made for a service or supply item. For example, some comprehensive prepaid health plans charge $1 for each office visit. Sometimes also known as "nominal" or "hesitation" payments.
UNDERWRITER	See "Carrier."
VALIDATION	Procedures for verifying the accuracy of data obtained from clients.
VOCATIONAL REHABILITATION	The process in which a disabled individual is assisted by one or more specialists in getting the training, education, and counseling needed to make the physical and/or social adjustments necessary to become employable.
WAITING PERIOD	A length of time, specified by a third party, from the beginning of an illness before benefits are payable. For example, under some medical insurance policies, the insured is eligible for benefits only after the seventh day of an illness.